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A Longitudinal Investigation of the Relationship among Social Support, Locus of Control and the Difficulty of the Transition to Parenthood as Experienced by Primiparae

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by

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CHAPTER ONE

INTRODUCTION

Overview

The early transition into parenthood is a period typically marked by dramatic changes in identity, social roles, marital and family relationships, financial status, sexuality, and physical and psychological functioning. With the birth of an infant, the entry into parenthood is no longer an anticipated event but a reality with which to be reckoned. LoPata (1971) contends that this transition causes disequilibrium in one's personality and lifestyle.

Theoretically, postpartum has been conceptualized on a continuum from a crisis, implying a significant psychological threat for child-bearing women (LeMaster, 1957; Kruckmann & Asmann, 1986), to a developmental transition, requiring intense adaptation tc the new parental role (Rossi, 1969; Jacoby, 1969). Historically, much of the medical, psychiatric and psychological literature on postpartum has reflected a preoccupation with dysfunction during this period (Kruckmann & Asmann, 1986).

However, Rossi (1969) and Jacoby (1969) have argued that research on postpartum with a focus on psychopathology

tends tc blind the investigatcr to the positive aspects of new parenthood. Rossi (1969) suggested a more normative definition and within the context of developmental theory, redefined postpartum as a life cycle transition. Developmental transitions, as such, were considered to include observable phases of intense adaptation, requiring mastery of phase-specific tasks. Rossi concluded that developmental transitions do not necessarily pose a concomitant threat of psychological dysfunction. Her work was seminal in guiding a reorientation of postpartum, viewing it from a more normative position rather than as an ex post facto opportunity for dysfunction.

Postpartum has been conceptualized as a normative, developmental experience within systems theory as well. It is viewed as one of many transitional periods which are integral to the life cycle of a family. Stress, related to the intense adaptation of these periods, is seen as endemic to transitions. It is particularly endemic to the postpartum transition because the incorporation of a new family member, the infant, necessitates a myriad of relational changes throughout the whole family system (Haley, 1973; Minuchin, 1974).

DeLongis (1967) identified the birth of an infant as one of the most stressful life events in adulthood. Research on mood changes in new mothers examined the

specific aspects of postpartum which engender stress. For example, although first-time parents reported early postpartum as a time of joy and excitement and relief from the tensions and anxieties of late pregnancy (Elliott, 1983), they also cited many stresses. The stresses include the obvious physical demands of caring for an infant, as well as less obvious demands, such as, the strain put upon the marital relationship; the emotional costs of the often overwhelming sense of responsibility for raising a child; the need to cope with feelings about one's ability and/or willingness to perform the necessary long term parental tasks; the restrictions on one's freedom; and the financial and career limitations that may occur as well (Miller & Sollie, 1980).

Research on infant mental health has clarified the importance of parental adaptation during the postpartum transition because of its impact upon the development of attachment. Attachment, identified as a gradual, interactive process between parent and infant, is essential to the life-long parent-child relationship and to infants' mental health. Parental adaptation during the postpartum transition has been linked to parent-infant attachment, with a lack of attachment being associated with high-risk families and child maltreatment (Williams, Joy, Travis, Gotowiec, Blum-Steele, Aiken, Painter, & Davidson, 1987).

Therefore, the importance of this period in relationship to the whole of the developing newborn family cannot be underestimated.

The focus of this area of research, however, has been primarily on the infant rather than the parent (Goldberg, 1983). There has been a need to explore the adult experience during this critical period in order to more fully delineate parental needs and thereby support the developing newborn family (Williams, et al., 1987). The present study has investigated this period as an adult experience.

The Current Investigation

Steffensmeier, (1977) operationalized the difficulty of the transition to parenthood with the design of an instrument to measure postpartum adjustment. Basing her work on developmental and social role theory, Steffensmeier (1977) concluded that the normative postpartum transition is comprised of three factors, which incorporate both stresses and rewards to new parents. Specifically, the factors are: parental responsibilities and restrictions (PRR), parental gratifications (PG), and marital intimacy and stability (MIS). These factors reflect the new situations and relational changes which accompany the birth of the first child. In the current study, the Difficulty of Transition instrument was used to measure the degree of difficulty

mothers experienced within these three factors in the normal, adaptive transition to parenthood. The assessment was a longitudinal investigation to further our understanding of the difficulty of this normal, adaptive process over time.

A burgeoning research on the role and function of social supports has documented that social support is a "significant determinant of individual differences in reactions to stress" (Cutrona, 1984). Generally, social support has been related to lower levels of psychological distress (Turner & Noh, 1981); and more specifically for primiparae, to fewer postpartum difficulties (Gordon, 1959). For example, marital support has been found to be a significant determinant in postpartum depression (Paykel, Emms, Fletcher, Rassaly, 1980; Wandersman, 1980; and O'Hara, Rehm, & Campbell, 1983).

One explanation for the role and function of social supports in relationship to stress, posits the "buffer" theory, in which social supports mediate stressful situations (Wilson, 1981). Weiss (1974), however, speculated that social supports function more globally. In the current investigation social support was defined as interpersonal relational assets which enable individuals to cope with life in high or low stress situations (Weiss, 1974). Weiss hypothesized that social supports provide the

1974). Weiss hypothesized that social supports provide the following specific relational assets or provisions: 1) attachment, which offers a sense of security and safety; 2) social integration, which offers a network of relationships with which one can share interests and concerns; 3) nurturance, which offers the opportunity to care and provide for the well-being of another person; 4) reassurance of worth, which offers acknowledgement and valuing of one's abilities; 5) reliable alliance, which offers practical assistance under any circumstances; and 6) guidance, which offers trustworthy and authoritative individuals who can give meaningful advice.

In addition, in a study of postpartum primiparae, Cutrona (1984) found that certain of these social support provisions were predictive of psychological reactions such as depression at eight weeks postpartum. However, the present study investigated the impact of social support relational provisions upon the non-symptomatic, adaptive process of the postpartum transition. It was measured with the Social Provisions Scale (Russell and Cutrona, 1984).

In research on the structure and use of social supports, Eckenrode (1983) found that social ties in and of themselves are not necessarily supportive. Rather, the reported helpfulness of social supports was associated with individual differences in locus of control. In a study of

postpartum depression, locus of control and socioeconomic status were correlated to the mobilization of social supports and their reported helpfulness (Riley & Eckentrode, 1986). For example, individuals with an internal locus of control, which is a belief system that posits attainment of rewards or reinforcement as dependent upon one's behavior, were more apt to mobilize their social supports and report them as beneficial than individuals with an external locus of control (Riley & Eckenrode, 1984). Generally, individuals identified as "internal" are less negatively affected by stressful life events (Johnson & Sarason, 1978; Sandler & Lakey, 1982). In the present study the relationship between locus of control and socioeconomic status during the adaptive, postpartum transition was investigated over time. It was assessed with the locus of control, internality versus externality, I-E Scale (Rotter, 1966).

The literature on postpartum as a developmental transition has documented that this is a highly stressful period of intense adaptation within adulthood. This period is viewed as critical to the on-going attachment and lifelong relationship between parent and child and to the infant's mental health. The literature on social supports and individual differences as mediators of stress has investigated their impact on women who have experienced

dysfunction such as depression during this transition. The current study examined the role and function of social supports and locus of control in relationship to the difficulty of the normal, adaptive postpartum transition. The length of transition was defined as five months postpartum and was assessed at three points in time, one month, two months, and five months postpartum.

Purpose of This Study

The purpose of this research was to investigate the normal, postpartum adjustment of mothers of first-borns. Two assumptions underlied this investigation:

1) Women experience postpartum as a developmental experience.

2) A more realistic expectation of the normal, adaptive postpartum transition is fundamental to facilitating the adjustment process and planning appropriate interventions when needed.

While infant mental health research has determined that attachment is a gradual, interactive process and crucial to the mother-infant relationship, the focus of this study was on the mother only. This investigation attempted to meet a need to examine the maternal side of the parent-infant relationship to better understand the mother's adjustment process "separate" from her infant's (Williams, et al., 1987). This study examined the mothers' side of adjustment over time to note normative developmental changes, if any. Based on empirical relationships suggested by previous

research on postpartum depression (Russell & Cutrona, 1984; Riley & Eckenrode, 1986), hypotheses regarding the impact of social support and locus of control were examined in relationship to postpartum adjustment.

A final purpose of this study was to increase the knowledge base of postpartum adjustment in order to better assess and prevent potential maladaptation. Maladaptation during the transition to parenthood has serious consequences for the development of parent-infant attachment and has been linked to high-risk families and child maltreatment. Therefore, anticipating and meeting parental needs during this period has positive consequences for the developing newborn family and the infant's mental health (Williams, et al., 1987).

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study was to examine the variables of social support and locus of control in relationship to the difficulty of the postpartum transition in primiparae across time. The following review will begin with a description of postpartum. This review will address the historical roots of postpartum research, as well as the present theoretical and empirical status of postpartum research today. Relevant theories and studies, as well as methodological and theoretical problems inherent in the study of postpartum will be discussed. Each of the independent variables of social support and locus of control will then be discussed. Relevant theories and research for each of these variables will be presented and critiqued.

Postpartum

Much of the early research on the family was sociological in nature. Within that context, the family was defined as a small working group or unit and was viewed as an integrated, social system, consisting of an intricate internal and external organization. The family's internal organization is comprised of paired roles for its members, such as wife-mother or son-brother. These roles encompass socially defined standards or expectations of behavior for

the individual. The family's external organization consists of its boundaries or openness in relationship to the larger society. Boundaries enable the family to handle problems privately and to choose to interact or not interact with the larger social system of which it is part (Hill, 1949).

From this system theory perspective, it was observed that both individual members and the family as a whole face many varied stresses throughout the life cycle. Early research on stress and its impact on the family focused upon stressors which provoked crisis reactions in the family as a unit. Crisis-provoking events were defined as severely upsetting environmental incidents of sudden onset which were of limited duration but had long-term consequences (Weiss, 1957). The impact of crises are severe because family members typically lack adequate preparation in adapting to the myriad of sudden changes which crises engender. Therefore, families are forced to hurriedly summon available resources in an effort to cope with these unexpected changes which threaten emotional and social stability (Weiss, 1957).

The degree to which a stressor causes crisis in a family is variable, depending upon two factors: the degree of hardship generated and the family's perception of the event as a crisis (Schulberg and Sheldon, 1968). Those stresses for which the family's usual pattern of action proves inadequate and the family views as critical are

characterized as "crises" and as such, pose significant problems for families (Hill, 1949).

The study of the family as a system was based on homeostatic theory, initially developed in the physical and biological sciences. Homeostatic theory posited that the goal of most human responses was to maintain the usual mode of functioning. In relationship to that paradigm, families' reactions to crises were examined. A general pattern of family response to crisis emerged (Hill, 1958; Hansen and Hill, 1964). First, a period of disorganization and disequilibrium was noted in which the family's usual system of social roles and behaviors proved functionally ineffective in handling necessary tasks; this was followed by a degree of recovery in the family's ability to function; and finally, there was a level of reorganization in roles and a return to a homeostatic state, which may or may not have reflected the preexisting level of functioning. This pattern of response incorporated a multitude of changes in the family's functioning as a social system, altering members' roles, values, relationships and means for meeting individuals' needs (Hill, 1958). Crises were clearly both physically and psychologically demanding.

The initial research on families' response to specific crisis events were situations of unexpected loss of a family member through death or divorce. However, as crisis research progressed, a clinical interest developed in

"expected" crises that families experienced throughout the life cycle. It was from this viewpoint that LeMasters' (1957) questioned whether "adding a new member to the family system could force a reorganization of the system as drastic (or nearly so) as does the removal of a member?" The view of the birth of the first child as a crisis event evolved from investigations of parents' experiences as they reorganized their relationships to incorporate their first child. The research question was whether the stress of this reorganization could be considered a crisis.

Postpartum Defined as Crisis

In a study of 46 middle class couples interviewed within five years of the birth of their first child, LeMasters (1957) reported that 83 percent indicated "extensive or severe" crisis in adjusting to parenthood. This "crisis" response was not related to an unplanned pregnancy or the quality of the marital relationship. Rather, the crisis in adjustment was associated with a variety of personal difficulties and losses as a result of having the first infant. For example, chronic fatigue, loss of the wife's income, and wife's worry over her physical appearence were typically cited. More generally, the subjects reporting extensive or severe crisis "felt that they had had very little, if any, effective preparation for parental roles." LeMasters concluded that new parents' complaint of a "lack of preparation" was a reflection of a

conflict between their romanticized expectations of parenthood and the harsh realities of their new roles than a true lack of preparation.

While this study controlled for education, marital and economic status, its retrospective view of new parents' experiences was thought to be a limitation. The period of time between the birth of the infant and data collection was as much as five years. Therefore, history and the potential for innumerable intervening variables may have weakened the association between the birth of the first child and the interview results.

In a restudy of first-time parenthood as a crisis, Dyer (1963) administered a questionnaire to 32 parents and also found a high degree of crisis. This sample was demographically comparable to LeMasters' sample except that the time between the birth of the infant and assessment was two years. Dyer reported that 53 percent of the sample experienced "extensive to severe" crisis in adjusting to their first child. Additional associations noted in this study were that couples reported less crisis 1) the higher they rated the quality of their marriage; 2) the number of years married was three or more; and 3) the birth of their infant had been planned. In contrast, couples reported greater crisis if fathers had no college degree and if the infant was six months or younger at the time of the study.

Dyer's study supported LeMasters' (1958) findings, that a majority of couples experience extensive or severe crisis following the birth of their first infant. Moreover, while 81 percent of the sample indicated that they had made fair to excellent recoveries, 40 percent were still reporting adjustment difficulties at the time of the study, which was on the average of 12 months after the birth of the child.

These studies became the foundation for research on parenthood as crisis. However, there has been little subsequent empirical evidence to support this view of parenthood as crisis. For example, in two follow-up studies, Hobbs (1965; 1968) sampled a cross-section of 53 and 75 first-time parents at 10 and 24 weeks postpartum, respectfully. Using a 23-item checklist of adjustment difficulties based on LeMasters' work, Hobbs' first study elicited only a 13 percent "extensive" crisis rating, 87 percent rating "slight" crisis, and none rating either extreme of "no" crisis or "severe" crisis. Altering the methodology, the second study incorporated the checklist and an additional interview. The checklist elicited the same percentages of crisis as the first study; however, in contrast to the inital study's finding of no "severe" crisis, the interview format evoked a "severe" rating for 20 percent of the mothers sampled.

Additional research which utilized the questionnaire format as Hobbs had done, uniformly found little to no "extensive or severe" crisis in primiparae (Beauchamp, 1969; Russell, 1974; Uhlenberg, 1969). However, the contradictory findings between the initial studies and these follow-up studies may be due in part to methodological issues. For example, the means of data collection may have affected subjects' responses. In trying to account for significantly higher "severe" crisis ratings elicited in an interview format in contrast to a questionnaire format used in previous research, Hobbs (1968) noted that parents may not as readily "mask their real feelings about a topic as sensitive as negative feelings which they have about their baby" in an interview format, as they may in a questionnaire.

In addition, the samples across these studies were quite divergent. LeMasters (1957) and Dyer (1963) assessed middle class, urban and primarily college educated subjects, while Hobbs' (1965; 1968) cross-section samples were more representative of the larger population. Therefore, it is unclear if comparable findings, such as those from LeMasters and Dyer's samples might have been dispersed in analyses of subsequent research, which examined a more representative sample of the larger population.

Another methodological limitation between the studies was the extreme differences in time between the birth of the

first infant and the data collection. The studies range of time was as much as 5 years and 2 years (LeMasters and Dyers) and as little as 9 weeks and 23 weeks (Hobbs and Russell). Therefore, the studies may have been investigating very different experiences, as maturation and history would not necessarily allow for control of intervening variables over such disparate time periods. In addition, the interaction of time and the bonding process, as it is currently understood, might not allow for the expression of negative feelings regarding one's baby during early postpartum. As Hobbs (1968) had suggested, subjects, who were assessed as much as 2 or 5 years following the first birth and reported severe crisis as in the initial studies, may be more able to acknowledge negative feelings "in retropect than they can during the time that they are experiencing them."

Another intervening variable may be the potentially confounding effect of the "baby honeymoon" (Feldman, cited in Hobbs, 1965), which may have affected the lesser crisis findings in the followup studies. Theoretically, the "honeymoon" phase for new parents is characterized by elation experienced in the first weeks of postpartum. Feldman hypothesized that only after the early weeks of this initial elation are individuals able to feel the full impact of their role changes and the demands of parenting. Therefore, it may be that it is only with distance in time

from the early honeymoon period, that one is able to acknowledge negative aspects of new parenthood (Feldman, 1965).

The present study investigated primiparae's experience of new motherhood during postpartum over time, beginning at 1 month, then at 2 and 5 months postpartum. The intent was to minimize potential effects of the "honeymoon" phase during the first weeks postpartum, but to note change across early to mid-postpartum.

The above should provide a sufficient, though not necessarily exhaustive, view of the early history and development of research on the transition to parenthood as a crisis-provoking event. Unfortunately, earlier research has produced inconclusive findings and has tended to focus solely on the negative effects of parenthood, neglecting its potentially positive or at the least, neutral aspects (Rossi, 1968; Jacoby, 1969). As developmental theorists examined the tasks and adjustments inherent in various life cycle transitions with more specificity, the primary focus on negative aspects of role changes was challenged and motivated other areas of study to more fully understand life cycle transitions.

Rapaport (1963) had proposed a further refinement of the concept of adjustment to expectable events within the life cycle, such as marriage and having the first child, as "normal crises." However, based on the assumption that most

individuals accomplish life cycle transitions, the term "normal crisis" was considered misleading and inaccurate because the principle of normality by definition implies a successful outcome (Rossi, 1968; Jacoby, 1969). Therefore, Rossi (1968) argued that normal and crisis were antithetical terms, and that a life cycle transition could be characterized as a crisis only to the extent that there was not a successful outcome or resolution. The early research on postpartum as a crisis had produced inconclusive evidence. Rossi (1968) and Jacoby (1969) criticized that body of research for focusing solely on the negative aspects of parenthood to the exclusion of its positive or at least neutral aspects. Rossi suggested that there was a need to more fully explore developmental transitions in relationship to both their positive and negative aspects.

Early developmental theorists defined personality as an ever-changing phenomena, which evolves in a continuous, stage-like pattern (Erikson, 1957; Benedeck, 1959). Change or development was viewed as taking place throughout the life cycle in relationship to critical life experiences. These theorists postulated that critical life experiences offered opportunities for the resolution and integration of elemental, intrapsychic conflicts and the acquisition of new social roles (Erikson, 1957; Benedeck, 1970; Deutsch, 1945).

There has been little empirical evidence, however, to support the concept of human development as simple movement

through a linear series of stages (Baltes, 1979; Cohler & Boxer, 1984). Rather, development or adjustment has been identified as a more complex, interactive process between 1) both normative and unexpected life events, 2) the historical context within which the individual lives, and 3) the socially shared expectations of the life span. Therefore, adjustment or normality is currently viewed as dependent upon the degree of congruence between the individual's subjective understanding of socially defined roles and the attainment of roles across the life span (Hill & Hansen, 1960; Cohler & Boxer, 1984).

Rossi (1968) classified these critical periods in role attainment as transitional phases. The theoretical value of the "transition" classification as compared to the "normal crisis" classification was that it encouraged the researcher to observe the overall impact of a role change upon development. This approach stimulated research which investigated both successful and unsuccessful outcomes including both positive and negative aspects of transitions. As demonstrated in previous research on the engagement and early stages of married life (Rapaport, 1963), Rossi used the task perspective to examine the transition to parenthood. Rossi speculated that every transitional phase has a cycle of development, including tasks and problems of adjustment unique to that stage of the life span. These developmental tasks and problems of adjustments are integral

to the acquisition of a new social role. This model allowed for a broader perspective of human development, which incorporates the potential rewards or gratifications in a role transition, as well as the tasks and difficulties of adjustment. The end result of transitional periods in human development, therefore, was conceptualized as the "establishment of a new stable life organization accompanied by a new stable identity" (Weiss, 1976).

The above review establishes support for the concept of developmental transitions within the life cycle; but what factors are relevant to the transition to parenthood and its impact upon adult development during this stage of the life cycle.

Postpartum as a Developmental Transition

Gordon and Gordon (1965; 1967) examined the psychosocial changes associated with early adaptation to the maternal role through an experimental, antenatal informal group, consisting mostly of primiparae. An experimental group, which participated in postpartum educational and support meetings, and a control group were evaluated for long term emotional reactions, subsequent deliveries, and physical reactions at 6 weeks, 6 months, and some between 4 to 6 years postpartum. The factor analysis of a previously designed scale which measured postpartum social stresses and discriminated women who would experience postpartum emotional upset (Gordon, 1959) found two factors that were

significant for both the experimental and control group. The Maternal Role Conflict factor reflected stresses in a woman's changing social role as a new mother, including concerns about progressing socially, educationally and economically, and a need for assistance and emotional support with the practical aspects of motherhood. The Personal Insecurity Factor reflected stresses associated with previous difficult life events, including insecurity in either parents' background due to an early death of their own parent, a general lack of experience with young children, or being a primipara. Gordon et al.(1959) found that women whose stresses were primarily related to the personal insecurity factor had shorter-term emotional difficulties than those who displayed maternal role conflict. A lack of practical assistance and emotional support were found to be most significantly associated with emotional upset lasting at least 6 months.

Gordon (1959) found that the following twelve guidelines, when presented in conjunction with an informal class format, allowed new parents the opportunity to discuss feelings of fear, inadequacy and frustration and to develop social ties among members. This model was subsequently associated with less maternal role conflict. The twelve guidelines were as follows: 1) The responsibilities of motherhood are learned, so there is a need to get informed. 2) Get help from husband, friends, relatives. 3) Make

friends with other child-rearing couples. 4) Don't overload yourself with unimportant tasks. 5) Don't move as soon as the baby arrives. 6) Don't be overconcerned with keeping up appearances. 7) Get plenty of rest and sleep. 8) Don't be a nurse to others. 9) Confer and consult with others and discuss problems and worries. 10) Don't give up outside interests, but cut down on responsibilities and rearrange schedule. 11) Arrange for baby-sitters early. 12) Get a family doctor early.

In long term follow-up at 4 to 6 years postpartum, 80 percent of the experimental group compared to 54 percent of the control group had overcome any depression they experienced initially; 66 percent of experimentals versus 36 percent of the controls had had another child; and 28 percent of experimentals versus 55 percent of the controls had had serious physical or emotional problems (Gordon, 1965).

It appeared that giving information and providing a format in which individuals could discuss their anticipated role changes and concerns, allowed new parents to rethink their attitudes and plan activities to incorporate both the responsibilities and rewards of the mother role. This in turn reduced the likelihood of postpartum emotional upset. Gordon (1965) suggested that it was not intraspychic conflicts or personal insecurity related to "misfortunes of the past" that engender the most emotional difficulties for

postpartum women, but practical day-to-day issues in the adaptation to the mother role.

In initial studies of the marital life cycle, parenthood appeared to pose difficulties for the marital relationship (Feldman, 1961; Meyerowitz & Feldman, 1966). Couples with young, pre-school age children manifested crisis-like qualities in the marital relationship. For example, in a short-term longitudinal study, Meyerowitz and Feldman (1966) examined the transition to parenthood and its impact upon the marital relationship of four hundred primiparous couples from the fifth month of pregnancy through the fifth week and fifth month postpartum. The subjects, between 21 and 24 years of age, represented a cross section of religious backgrounds; 20 percent had been married more than 3 years; and 15 to 25 percent had been pregnant at the time of their marriage.

The couples' subjective response to parenthood was compared to the objective reality of marital changes following the birth of the first child. The most significant finding was that the couples reported a higher level of marital satisfaction at 5 months postpartum but a twenty percent decline (85% to 65%) in amount of time that things are "going well" between pregnancy and one month postpartum to five months postpartum. An unspecified increase was also reported in their frequency of pleasurable incidents during the postpartum months such as "laughing

together", "having a good time", and "calmly discussing something". The results suggested that, objectively, stresses increased between 5 weeks and 5 months postpartum; but, new parents experienced pleasure within the marital relationship during that period nonetheless.

In another study on the transition to parenthood and the marital relationship, Russell (1974) sampled 290 working and middle class couples within a range of 6 to 56 weeks postpartum and a mean of 29 weeks postpartum. This study included a gratification checklist as well as a degree of crisis checklist and a marital adjustment form. The gratification checklist assessed those things the couple might enjoy in their new parental roles.

The crisis results of this investigation were comparable to earlier findings. There was only a moderate degree of crisis noted, although more so for wives than husbands. The stress of postpartum appeared to be related to more personal, individual types of difficulties such as fatigue, loss of wife's figure, and financial strain, than to a disruption in the marital dyad (Russell, 1974).

Generally, marital adjustment and the baby's temperament, "quiet versus active," were found to be significant variables in relationship to crisis scores for both parents. A high degree of marital adjustment and "quiet" babies were associated with lower stress for both parents.

Gratifications, defined as those things parents enjoyed in their new roles, were also assessed. Both parents tended to check more gratifications than crisis items, and the gratifications represented more personal kinds of rewards or pleasures than things shared with the spouse or other relationships. Overall marital adjustment was positively associated with greater gratifications for mothers. Marital adjustment was associated with greater gratifications for fathers when there was a change in a positive direction in marital adjustment over the postpartum period.

In addition, the variables of education, socioeconomic class, age of mother and length of marriage were also found to be significantly associated to gratifications during postpartum. For example, higher education was negatively associated for both parents with gratifications. Middle class subjects reported fewer gratifications than lower class parents. The longer the marriage for women under the age of 23 the greater the number of gratifications reported. For women over the age of 23, the longer the marriage the fewer gratifications reported. Although Russell (1974) suggested that social desirability is an issue in interpreting the meaning of the gratification data, the value of this study is that it confirmed empirically that the transition to parenthood includes positive rewards as

well as stresses and education and socioeconomic status appear related to reported gratifications.

A limitation in this study was the number of non-respondents. The original sample of 511 represented a 20 percent random sample of all primiparous births in married couples for a one year period. Of this sample, 45 percent did not respond to any of three mail and telephone contacts. The non-respondents were younger, less educated, and more likely to have been pregnant at the time of marriage than the respondents. However, as the non-respondents may have self-selected to stay out of the study due to degree of stress or lack of gratifications in the parenting role, it is unclear in what direction their responses would have influenced the perception of crisis or stress and gratifications in first-time parents.

Steffensmeier (1977; 1982) more specifically operationalized the positive and negative aspects of the transition to parenthood with the design of a measure to assess the level of difficulty experienced in the role transition to parenthood. In a factor analysis of the difficulty of transition items, the variety of changes that couples experienced fell into three factors: 1)Parental Responsibilities and Restrictions (PRR) which reflects concrete and specific effects of the baby's birth upon the marital couple's lifestyle, for example, loss of sleep, not

being able to get out of the house, or curtailment of social activities; 2) the Parental Gratifications (PG) which reflect the rewards of parenthood, for example, feeling happy, a purpose for living, or closer to one's spouse; 3) Marital Intimacy and Stability (MIS), which reflects concerns regarding the lessening of intimacy due to the incorporation of the infant into the marital dyad, for example, worry about sexual relations, not giving spouse enough affection and attention, and talking with spouse.

Steffensmeier concluded that the difficulty of the transition to parenthood is multidimensional. In terms of the variance, it appeared that sex had a direct effect on parental responsibilities and restrictions with women experiencing more difficulty than men in this area. Education for women was associated with more difficulty within the PRR factor as the higher the education, the greater the difficulty in this dimension. Education was inversely related to parental gratification for both men and women. For example, the higher the education the more planned was the pregnancy but the fewer the gratifications experienced. These data supported Russell's (1974) findings of a negative relationship between education and parental gratifications.

A primary value of this study was the construction of a tool to empirically measure the difficulty of the

transition to parenthood which incorporated associations found in previous research (Hobbs, 1965: Beauchamp, 1969; Russell, 1974). As such, the measure of transition difficulty included both positive and negative aspects of new parenthood that were statistically found to be internally consistent, reliable and only slightly correlated to each other.

Taking a holistic approach in an exploratory, descriptive study of 19 white, middle-class primiparae, Leifer (1980) investigated patterns of normative adjustment which could function as baseline data on pregnancy and postpartum, including the physical and emotional demands of new motherhood. The methodology included five interviews in total; three during pregnancy and at 3 days and 2 months postpartum. In addition, a questionnaire was sent at 7 months postpartum.

Leifer found that during the first two months postpartum, women reported that the physical demands of the mothering role tested their emotional capabilities. More specifically, mothers felt the baby's needs as intense and their own physical resources, in terms of stamina and energy level, as low. Subjects also reported a sense of disequilibrium during the first weeks, although that lessened significantly at one month postpartum. Nonetheless, two-thirds of the sample reported depressive

periods of an "intense and pervasive nature" throughout the first three months postpartum.

In addition, the subjects reported significant anxiety during the first month postpartum, related to feelings of inadequacy in mothering skills and fears regarding their infant's well being. Anxiety continued into later months as well. However, anxiety in later postpartum was less directly associated with mothering skills and the infant's status and more with depressive mood changes that the mothers did not perceive as typical of themselves. The mood changes appeared to conflict with their understanding of the larger society's definition and expectations of the "good" mother. The implication was that "good" mothers do not experience depressive mood.

Moreover, all the mothers experienced an increased dependency upon their husbands during postpartum due to a number of factors. They seemed to need their husbands as an external source of reassurance regarding their abilities to mother successfully; as a means for adult stimulation to counteract their new sense of social isolation; and as a means for emotional replenishment in the face of physical and emotional exhaustion. Leifer hypothesized that maternity required changes in the female gender role that were more sharply differentiated and more strictly defined by traditional social constraints than men experienced with

the advent of fatherhood. The data suggested that many of the subjects, even those who were not career-oriented and therefore, not generally in conflict with the social standard, found these changes "disconcerting and troublesome."

This study supported the view of new motherhood as a stressful period. Leifer concluded that the transition to parenthood is a developmental event that necessitates a complete change in lifestyle and adjustment to changes in social roles in order to return to a state of equilibrium.

While a limitation of this study was the small sample size (N=19), which affects its generalizability; its value lies in its longitudinal assessment of change in women experiencing the transition to parenthood. However, as Leifer suggested, there is a need for additional longitudinal study of larger and more representative samples of women's reaction to the mothering role and its effect upon their development. The present study, which is longitudinal, examined developmental change over time during the first 5 months postpartum, with the exploratory intent of specifying a more detailed account of the transition experience and examining other potentially intervening variables that might affect a woman's response to new motherhood.

In another longitudinal investigation of maternal mood and attitudes, Fleming, Flett, Ruble and Shaul (1988) substantiated Leifer's findings that the transition to parenthood affects one's lifestyle and sense of self. The postpartum mood state was found to be a more potent predictor of maternal feelings than pregnant mood state.

The infant's state of health was not a factor in maternal mood until the third month postpartum. At that point in time, infant health appeared to become a factor to the extent that it had a cumulative effect upon mother's gratification in caretaking. Therefore, as compared to fatigue and social support, infant's health influenced maternal mood indirectly (Fleming, et al., 1980).

While maternal mood was not found to affect mother's feelings of attachment to their infant or ability to meet instrumental needs, mild dysphoria did appear to affect emotional or social interaction between mother and child. For example, dysphoric mothers displayed fewer affectionate behaviours toward their infants. The absence of these interactions are thought to have a negative effect upon infant development (Williams, et al., 1987).

This research indicated that fatigue and social support are associated with women who experience depressed mood, even if only mild dysphoria, during early postpartum. While they are able to meet their infant's practical,

caretaking needs, they do not appear to feel positively about themselves as mothers; subsequently, displaying fewer social and affective interactions with their infants. Although maternal mood effects upon mother-infant interactions were no longer perceptible by 16 months postpartum, its impact upon the mother-child relationship during later development is not clear.

As the above review suggested, the research on the transition to parenthood as a stage in adult development has empirically confirmed a number of factors that contribute to this period being assessed as the sixth most stressful event out of 102 life events (DeLongis, 1967). First, the physical demands of pregnancy and delivery leave many women's physical capacity at an extremely low and atypical level during a time when the instrumental demands of caring for a new infant are high. Moreover, in the process of mastering concrete parental skills and adapting to the maternal role, a woman's sense of herself is disturbed as she struggles with common feelings of inadequacy and a generalized psychological disequilibrium in her identity and social relationships (Benedeck, 1957; Erickson, 1957; Rossi, 1968; Jacoby, 1969; Leifer, 1980). In addition, mildly dysphoric mood (Fleming et al., 1980; Leifer, 1980) and anxieties related to the infant's well-being as well as

maternal adequacy are typical experiences during the first months of postpartum.

The present study, which is based primarily on developmental theory (Rossi, 1968; Jacoby, 1969), examined postpartum as a life cycle transition in which the acquisition of a new social role requires mastery of a unique set of tasks and includes issues of adjustment. While the transition to parenthood has been shown to be physically and emotionally demanding, and socially isolating, it encompasses positive aspects as well.

Steffensmeier's (1977) research was important to the present study as she operationalized the developmental view of postpartum as a transition with the construction of the "Measure of Transition Difficulty." This measure was designed to empirically assess the postpartum adjustment process including changes within the self, the marital relationship, and social milieu. In that way, this transition can be examined as an individual, psychological experience within a social context.

Moreover, while much of the research cited has been limited in duration, the present study has taken an exploratory view of the transition to parenthood over time by investigating change longitudinally. Thus, the focus of the present study is on the transition to parenthood as a normal, adaptive process over time.

As discussed above, while the transition to parenthood has been found to be disquieting and extremely stressful, most individuals are able to manage the adaptive process. Therefore, the transition to parenthood, as one of many life cycle transitions, is viewed less as a crisis implying maladaptiveness and more as a developmental opportunity for personality change, reorganization and integration (Benedek, 1959; Caplan, 1961; Erikson, 1959; Parsons and Bales, 1955). Two areas that have been shown to be significant variables in the transition to parenthood, as experienced by women, have been the perception of social support during this period and an individual difference in locus of control. Literature on these two variables will be presented next as relevant to the first-time mother's adaptation during the transition to parenthood.

Social Support

Historically, there has been a long-held view within the medical and psychological communities that the postpartum period poses an elevated risk of psychological distress for women (Kruckman, 1986). Social support has been identified as an important factor in some psychological reactions during postpartum, such as depression (Paykel, Emms, Fletcher, and Rassaby, 1980). In terms of types of support, marital support has been associated with lower

postpartum depression (Brown, Bhrolchain, and Harris, 1975; Brown and Harris, 1978; O'Hara, Rehm, and Campbell, 1978; Cutrona, 1984). More recent research has also shown that social support is an important factor in normal postpartum adjustment as well (Wandersman, Wandersman, and Kahn, 1980). The theoretical and empirical evidence for this view will be reviewed in the following literature.

The theoretical explanations for the mechanisms by which social support functions in psychological adjustment are varied. Much of the research and theories on social support have been based on the interrelationship among life events, social support and distress (Cobb, 1976; Dean and Lin, 1977; Gore, 1978; Billings and Moos, 1981). Within this context, two primary schools of thought have emerged to explain the mechanism of social support. One school of thought presents the "buffering hypothesis" (Cobb, 1976) which suggests that the function of social support is primarily in relationship to stress. Within stressful periods, the support system obviates or buffers the effects of stress upon the individuals' psychological state. However, the nature of life is such that the individual faces many periods of stress whether due to developmental transitions or unexpected crises throughout the life span (Cohler and Boxer, 1984). In either situation, the "buffering" theory is based on the premise that social

support's primary function is in relationship to stress. Therefore, individuals with little or no social support in the face of high stress appear more vulnerable to psychological distress and/or dysfunction.

The other school of thought views social support as more of a "main effect," in which the support system affects the individual's sense of well-being regardless of the existence of stressful events (Andrews, Tennant, Hewson, & Vaillant, 1978; Lin, et al., 1979). Therefore, psychological adjustment is thought to be directly linked to the individual's degree of social support whether in high or low stress situations (Caplan, 1974).

Within more recent research, an interactional or reciprocal model has evolved that integrates both the buffering and main effect theories (Thoits, 1982; Cutrona, 1984). Within the interactional model, it is speculated that the efficacy of social support influences the intensity of life events and the intensity of life events affects the efficacy of social supports (Cturona, 1984). This model has both theoretical and empirical support.

Robert Weiss (1974) proposed a multidimensional view of social relationships as supportive to others to the extent that social relationships provide a variety of assets or social "provisions." He identified six areas of social

provisions or relational assets that social relationships provide: 1) attachment is a sense of security and safety; 2) social integration is a network of relationships in which individuals share interests and concerns; 3) nurturance is feeling responsible for the well-being of another, thereby feeling needed by; 4) reassurance of worth is the acknowledgement of one's skills and abilities by others; 5) reliable alliance is having others to count on for assistance under any circumstances; 6) guidance is having trustworthy, authoritative individuals who can give advice.

Weiss further postulated that different types of social relationships may offer different social provisions, and/or that a single relationship can provide more than one provision. For example, members of the family of origin are are predominantly associated with reliable alliance; while the marital relationship appears to provide a range of social provisions. In addition, Weiss suggested that individual provisions may be more or less important during different periods of life but all of the provisions are necessary for optimal functioning.

Empirical research designed to examine social support theories in relationship to the transition to parenthood have primarily focused on pathological reactions, such as postpartum depression. This area of research has identified a number of associations between postpartum depression and

social relationships. For instance, a lack of relatives and friends to offer assistance (Gordon, et al., 1965; Wandersman, et al., 1980), a lack of a confidante other than the spouse (Paykel, et al., 1980), a conflict between the new mother and her parents (Ballinger, Buckley, Naylor, & Stansfield, 1979), and marital difficulties (Ballinger, et al., 1979; O'Hara, Rehm, & Campbell, 1983) are parts of the social support system that have been linked to postpartum depression. With the operationalization of Weiss' relational provisions in the Social Provisions Scale (Russell & Cutrona, 1984), the mechanism by which social support may interact with postpartum depression and stress could be examined (Cutrona, 1984). While psychological dysfunction was not the focus of the present research presented herein, Cutrona's investigation offered a means to study more globally the mutual effects of social support and stress upon each other during the postpartum, transition period.

In a 12 month, longitudinal study (Cutrona, 1984), 85 primiparae were assessed for non-psychotic depressive symptoms at four different points in time, from late pregnancy to one year postpartum. The goal was to determine if depression could be predicted from the prenatal social support system and postpartum childcare-related stress. At 2 weeks postpartum, prenatal social support was not

associated with depression. However, prenatal social support was associated with postpartum depression at 8 weeks postpartum. Therefore, Cutrona (1984) suggested that depression at 2 weeks postpartum may more accurately reflect hormonal changes; while depression at 8 weeks postpartum may reflect social support.

Although, overall social support appeared unchanged over the first year postpartum, the degree of particular social provisions provided by the support system did change. For example, significant associations and trends were found between depression and two of the assistance-related provision: reliable alliance, which are social supports that provide practical help, approached significance at both 2 and 8 weeks postpartum, and guidance, which are social supports that provide advice and direction, were significant at 8 weeks postpartum and at 2 months postpartum in interaction with childcare-related stress. Therefore, it appears that assistance-related and guidance-related social support is significant to new mothers' mood within the first 8 weeks of giving birth, especially in relationship to the degree of childcare stress experienced.

In terms of the mechanisms by which social support affects postpartum adjustment, Cutrona (1984) has suggested that assistance-type of provisions may facilitate problem-solving for inexperienced mothers by providing both

tangible and intangible aid which may lower the amount of stress new mothers experience on a day-to-day basis. This in turn may lower their "cognitions of helplessness" (Cutrona, 1984, p.38).

The group membership provisions, such as "social integration" may provide social recreational activities which facilitate positive reinforcement. They also provide the means for normalizing a primipara's experience through interactions with other mothers, in which she can learn that the joys and difficulties she experiences in the postpartum transition to parenthood are not unique. Another social provision, reassurance of worth, may have a positive effect on one's self-esteem by encouraging confidence in one's ability to cope with difficulties.

Therefore, it is theorized that social support may function in two ways in relationship to postpartum psychological adjustment. Social support can have a direct effect on adjustment by providing concrete assistance in coping with problems, which is most dramatic during periods of high stress; and/or it can enrich emotional health by providing a reliably supportive environment regardless of the stress level.

Cutrona proposed, however, that social support may also have limited utility in the face of the highest levels of stress. For example, while the overall social provisions

score did not change across time in Cutrona's study, in fact, a large increase in "nurturance" counterbalanced a decrease in two of the provisions, "attachment" and "reassurance of worth". The value of "attachment" and "reassurance of worth" is that the individual receives benefits from others, in contrast to "nurturance" in which the individual gives care to another. It is hypothesized that caring for another provides the caregiver with a sense of being needed and as a result, worthwhile. However, in the face of very high stress, such as in the transition to parenthood, an increase in nurturance could be viewed as a relatively negative outcome as it implies increased demands in work and responsibility at a time when a new mother's stamina and emotional capability are low.

Cutrona's research provided important longitudinal data in delineating the role and function of social support in the transition to parenthood but with a more pathological focus on depressive reactions to postpartum. Another area of research that has investigated this transition in a more normative context, has been the study of marital adjustment in relationship to postpartum adjustment. This research has examined the marital relationship and social supports during the transition to parenthood in well-functioning individuals who were free from psychological symptomology. These studies have found modest but significant negative changes

in the marital relationship with the advent of the first child.

For example, in an initial longitudinal study of marital change during the transition to parenthood, Belsky, Spanier, and Rovine (1983) noted a modest but highly reliable decline in overall marital quality and functioning throughout 9 months postpartum with wives presenting more dramatic change than their husbands. The study consisted of both multiparous and primiparous couples. Although the primiparae generally showed a significantly higher quality of marital adjustment than the multiparae, both groups reported decreases in all areas of marital quality.

First-time parents showed a decline in a number of areas of marital adjustment during the first 3 months postpartum, with wives displaying more dramatic decline in quantity and quality than their husbands. For example, positive marital interactions significantly decreased during 0 to 3 months, but showed only a modest decrease from 3 to 9 months. Couples' sense of the marriage as a partnership increased significantly throughout the 9 months postpartum, while the marriage as a romance showed a consistent, though less significant decreasing trend. Marital affection decreased significantly but only during 0 to 3 months postpartum. Wives, in general, showed a sharper decline in

marital cohesion as compared to their husbands over 9 months postpartum.

A number of conclusions were drawn from these data. First, overall marital quality appeared to decline with the birth of the first child and continued with each additional child. However, the birth of the first child had the greatest impact, which tended to take place during the first three months postpartum. The most dramatic and significant changes in a negative direction in couples' affection, positive marital interactions and marital cohesion were noted during this period. Moreover, the nature of the marital relationship following the birth of the first child appeared to change focus as well, from that of an emotional romance to an instrumental partnership. Finally, the addition of an infant appeared to be more difficult for wives than husbands because while wives initially displayed greater marital quality than their husbands, they subsequently experienced more dramatic decreases following the infant's birth (Belsky, et al., 1983).

Although the group as a whole showed a significant decline in marital quality, individuals remained relatively stable across time. For example, there was little change in the rank ordering of couples and individuals at 3 months and 9 months on both self-reported and observed measures of marital functioning. Therefore, it appeared that the

dramatic changes noted in early postpartum level out by 9 months postpartum.

In a follow up study, Belsky & Rovine (1984) investigated the quantity and quality of social support to better understand the means by which individuals and couples coped with the changes taking place during the transition to parenthood. Material, emotional, and child care support were examined in relationship to frequency of social support contact and the value couples placed upon the family members who provided the support. Geographical proximity was not a factor in explaining the frequency or type of support first-time parents received throughout 9 months postpartum except for child care or babysitting support. Physical proximity also did not affect the value or meaning new parents put upon this support. For example, new parents who lived in closer proximity to their families of origin did not identify their family members as "significant others" any more so than new parents who lived far from their families of origin.

In general, primiparous couples seemed to experience more material and emotional support than multiparous couples. For the primiparous group, social support was at its highest during the first three months postpartum and declined by 9 months postpartum. However, when social network contact and types of support were analyzed across

two periods, at 6 and 12 months postpartum, individual differences, such as rank ordering of frequency of contact, remained stable. Therefore, the nature and function of couples' social support network appeared to remain the same over the first year postpartum as it had been prior to the birth of the first child.

Additional research on the the transition to parenthood, which examined its impact upon the marital relationship with more specificity, reconfirmed the general patterns found previously (Belsky, Lang, & Rovine, 1985). The birth of the first infant was associated with modest but consistent declines in couples' overall marital satisfaction, positive maintenance and behaviors, feelings of love, and the identification of the marriage as a friendship and a romance. Moreover, significant increases were noted in couples' feelings of ambivalence and identification of the marriage as a partnership. These results suggested that the marital relationship became less focused on the emotional needs of the parents and more focused on the instrumental needs necessitated by parenthood.

While group analysis demonstrated overall decreases in marital quality, individual differences remained stable, as both the couples and individual spouses maintained their rank ordering over one year postpartum. For example, wives

showed sharper declines in marital satisfaction throughout 9 months postpartum than the husbands, but by one year postpartum, the wives' marital score leveled out, resulting in closer husband-wife correspondence.

However, as the subjects in this and the previous study on marital effects were well-educated, well-functioning, middle class volunteers, the degree of change during the first year postpartum may be an underestimate for the population-at-large (Belsky, et al. 1985).

Belsky (1985) proposed that variability in marital change during the transition to parenthood has a multitude of determinants, such as infant temperament, social supports and new parent's expectations. He defined "violated expectations" as an incongruity between parents' prenatal expectations and the reality of the postnatal experience and found that violated expectations had a significantly negative association with marital adjustment, particularly during the first 3 months postpartum (1985). While the average parents' prenatal and postnatal expectations and experience tended to be similar, for those who demonstrated "violated expectations", there were significant decreases in love and satisfaction, and increases in ambivalence and conflict.

Belsky (1985) concluded that most marital change took place within the first 6 months postpartum and that it was the result of violated expectations that made that period particularly difficult for first-time parents. These data supported the findings in previous research that women appeared to feel the changes of parenthood most dramatically as their lifestyles and expectations regarding their lifestyles change the most. Belsky suggested that it was the tendency to overestimate the benefits of parenthood or the failure to anticipate its difficulties that resulted in violated expectations and potentially negative consequences for the marital relationship.

There are a number of conceptual and methodological problems with past research in the area of social support and the transition to parenthood which affects the types of measurements that have been used and issues that have been studied. A major issue has been been the pathological orientation of much of the research, such as a focus on postpartum depression. There is a continuing need to investigate this period as a normative, developmental transition and the role of social support upon it.

There have also been limitations in the research related to the following: a lack of precise, shared definitions of social support; inadequate forms of measuring variables; a lack of clarity between types and sources of

social support, and the mechanisms by which they are effective in aiding adjustment and/or relieving stress; the neglect of the impact of some individual differences such as personality characteristics upon social support; and the failure to take into account the ambiguous or negative effects of social supports (Thoits, 1982; Dean & Lin, 1977; Billings & Moos, 1981; Riley & Eckenrode, 1986; Gentry & Kobasa, 1984; Suls, 1982).

The present study does not speak to all of these limitations but it does address a number of them. In this research, social support was restricted to the types or attributes that social relationships provide, such as social provisions (Weiss, 1974). The Social Provisions Scale (Russell & Cutrona, 1984) which has both high reliability and validity (as discussed in Chapter 3), was used to measure the perceived type of social provisions with regard to their supportiveness. This study examined the relationship of perceived social support provisions to the difficulty of the transition to parenthood. The role of individual differences or personality characteristics was at least partially addressed through the measurement of the variable of locus of control, which will be discussed next.

In summary, the present study endeavored to avoid past methodological and theoretical problems by employing a clear definition of social support and reliable and valid

instrumentation (See Chapter Three). Moreover, this study explored the various relational provisions that social support provides and their impact upon the difficulty of the transition to parenthood. Individual differences in locus of control and socioeconomic class were also taken into account.

Locus of Control

While social support has been associated with less psychological distress, particularly in middle and upper socioeconomic groups (Turner & Noh, 1981), the mechanisms by which social support affects stress have been largely unexplained. The variable of locus of control (Rotter, 1959), investigated in relationship to social support, help-seeking behaviors, has been associated with better psychologcial adjustment. For example, individuals with an internal locus of control, a belief system that posits attainment of rewards or reinforcement as dependent on one's behavior, generally show better psychological adjustment than those with an external locus of control, a belief system that posits attainment of rewards as independent of behavior (Rotter, 1959; Strickland, 1978). In addition, externals appear more susceptible to negative effects of stressful life events than internals, as they show higher

correlations between negative life events and psychological symptomology (Johnson & Sarason, 1978).

Sandler and Lakey (1982) suggested that social supports may more effectively buffer stress in interaction with an internal locus of control. They found that while external individuals reported a greater number of social network contacts than internals, externals displayed significantly greater depression and anxiety in the face of stressful events than internals. It would appear that internals and externals may use or mobilize social supports differently.

In addition, research which examined the relationship between sociodemographic variables and stressful life events found that stress appears to have a greater impact on individuals from the lower socioeconomic status (SES) than those from the higher SES (Thoits, 1982; Turner & Noh, 1981). In an effort to delineate variables which might influence the socioeconomic relationship to stress, Eckenrode (1983) investigated locus of control in relationship to the mobilization of social supports.

Eckenrode's study sampled 308 randomly selected women who had experienced at least one stressful life event in the past year. The subjects mean age was 34.7 years, with a mean annual income of $7,500 to $10,000 in 1979 and twenty-two percent of the sample were Spanish-speaking.

Methodology included use of the Health Locus of Control Scale (Wallston, Wallston, Kaplan & Maides, 1976 cited in Eckenrode, 1983, p.516), which is based on Rotter's internal/external locus of control measure, I-E Scale (Rotter, 1966). While using an adaptation of the I-E Scale affects its generalizability, the results, nonetheless, suggested that the quantity and quality of the social network were not the only determinants in the efficacy of social support. Rather, the individual difference of an internal locus of control for middle and upper SES subjects, was positively related to the effectiveness of support network contacts during stressful events. Wile internals did not have a larger, potential social network than externals, they appeared able to use their support network more effectively during periods of stress. This data supported Sandler and Lakey's (1982) earlier finding that while externals report a larger number of social support contacts during a given period than internals, internals demonstrate greater stress-buffering.

In a follow-up study, Riley and Eckenrode (1986) found additional differences in the reported helpfulness of mobilized social supports, dependent on the receiver's personal resources. For example, individuals with an internal locus of control and higher income and educational levels reported greater satisfaction in their mobilized

social supports and higher levels of psychological well-being in response to stressful life events. Whereas, individuals with an external locus of control plus lower income and educational levels reported a greater number of social support contacts but significantly less helpfulness from those contacts. They also displayed a lower level of psychological well-being. The researchers concluded that the assumption that the mobilization of social support is always beneficial is too simplistic a view. Rather, for individuals with fewer personal resources, the mobilization of social support may actually result in "negative support" (Riley & Eckenrode, 1986).

The researchers suggested that the negative support process can be understood in relationship to the phenomenon of "contagion-of-stress", in which psychological distress is caused by undesireable events happening to significant members of one's social support network. While individuals with greater personal resources, such as higher income and education and an internal locus of control, tend to have larger supports networks and subsequently, a greater frequency of undesireable events happening to others in their support network, they report significantly less psychological distress. Whereas, individuals with fewer personal resources, such as lower income and education and an external locus of control, may report fewer undesireable

events happening to members of their social network, they experience significantly greater psychological distress to themselves. Riley and Eckenrode suggested that individuals with fewer personal resources may be at greater risk for contagion-of-stress because they lack material and/or psychological resources with which to be of assistance when an important member of their support network is in need. Consequently, individuals with fewer personal resources may not be as receptive to getting help from others as they function with the general expectation that they will not have the material or psychological resources to reciprocate should the need arise. Therefore, it does not appear to be the quantity of social supports or stressful events that affects adjustment, but the quality of one's ability to give and receive help from the support system in times of stress.

A major limitation of this study was that the data was collected at one point in time. Therefore, it is possible that the subjects' current level of psychological distress might have influenced an underreporting of social support and an over reporting of stressful life events with the social network (Riley & Eckenrode, 1986). The present study's longitudinal methodology was intended to counteract this effect and present more valid results by taking measurements at three points in time and therefore noting trends.

In general, the current investigation was meant to clarify any association between the amount and type of difficulty a new mother might experience in the transition to parenthood in relationship to locus of control. Moreover, in the present study, the relationship was examined between types of social provisions that the social support system provided, locus of control, and difficulty in the transition to parenthood. Socioeconomic status was controlled for with subjects limited to middle and upper SES categories. One research interest was to explore these groups with more specificity to examine Riley and Eckenrode's (1986) findings that these two SES groups display higher personal resources in greater internality in locus of control.

Summarily, the literature demonstrates the transition to parenthood is a significant social phenomenon. Prior research indicated that some reactions to the transition to parenthood are moderated by social support and locus of control. In this investigation an attempt has been made to study the transition to parenthood as a normative, developmental experience. The investigation has also attempted to measure the variables of social support and locus of control which have not been studied collectively or longitudinally. In this chapter, prior research on these variables has been presented. Theoretical and methodological

limitations have been discussed. The current study has attempted to remedy a number of these limitations through the use of clear definitions and reliable and valid instrumentation.

CHAPTER III

METHODOLOGY

This investigator obtained a measure of postpartum transition difficulty in primiparae at three points in time: at one month, two months, and three months postpartum. The variables of social support and locus of control, which are thought to mediate the degree of postpartum transition difficulty, were also measured. In this chapter, the hypotheses, subjects, procedures, research design, and statistical analysis used in this investigation are presented.

Hypotheses

The following null hypotheses were tested:

1. There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for each dimension of postpartum transition difficulty.

2. There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for social support.

3. There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for locus of control.

4. There is no significant relationship between transition difficulty and social support.

5. There is no significant relationship between transition difficulty and locus of control.

Subjects

Selection. The investigator contacted the Chairperson and Head Nurse of the Department of Obstetrics and Gynecology at a local, urban hospital and briefly described the research presented herein. Upon their recommendation, the investigator contacted the Chairperson of the hospital's Institutional Review Board (IRB) by telephone. The investigator then sent a brochure describing the proposed research, and a copy of the instruments to be used in the study to the IRB chairperson. A copy of the brochure and the instruments are contained in Appendix B. The investigator next met with the hospital IRB to answer questions regarding the study. The selection of this facility was based on current working relationships with the Departments of Family Medicine and Obstetrics and Gynecology with which the investigator was associated. After receiving IRB approval, the investigator made the following specific arrangements for data collection.

Subjects were limited to consecutive, consenting obstetrical, inpatients who met the selection criteria:

primiparae who had had a single birth; between the ages of 25 through 35; married at the time of delivery; and with infants within the normal range of health status at the time of birth.

Description. Demographic data (Table 1) were obtained at the time of the first assessment at one month postpartum from the group of subjects (N=30).

The subjects ranged in age from 25 years through 35 years. The median subject age was 29 years. Seventy percent (N=21) of the sample was white, fourteen percent (N=4) black, ten percent (N=3) Hispanic, and six percent (N=2) Asian.

All subjects were married. This was the first marriage for ninety-three percent (N=28) of the sample; seven percent (N=2) had been married more than once.

The primiparae's level of education ranged from high school through graduate school. Seventeen percent (N=5) of the sample had a high school degree, thirty-three percent (N=10) had some college education, thirty percent (N=9) had a bachelor's degree, and twenty percent (N=6) had graduate education including degreed and non-degreed.

Twenty-six percent of the subjects were employed full-time as homemakers, seven percent were employed full-time outside of the home with no maternity leave specified, ten percent were employed part-time, seven

percent were unemployed, and fifty percent were on an authorized maternity leave from full-time employment. The lengths of maternity leave ranged in time from six weeks to six months. The average length of maternity leave was twelve weeks.

Economic data were available for 29 of the 30 subjects. For purposes of this study, yearly household income segmented into four categories: 1) under $20,000, 2) $20,000 to 34,9000, 3) $35,000 to 49,900, and 4) $50,000 and above. Three percent (N=1) of the subjects had a yearly income of under $20,000, which reflected the spouse's foreign student status. Twenty-four percent (N=7) had a yearly income of $20,000 to 34,900; forty-two percent (N=12) had a yearly income of $35,000 to 49,9000; and thirty-one percent had a yearly income of $50,000 or more. In comparison to governmental statistics based on race and level of education (U.S. Bureau of the Census, 1989), three percent (N=1) of the subjects yearly income was equal to the median income of a comparable group by race and educational level; twenty-five percent (N=7) were below the median income of the comparable group; and forty-one percent (N=12) were above the median income of the comparable group. Precise economic status was unclear from the data for thirty-one percent (N=9) of the sample, but their income was within a

range that was at or above the median income of the comparable group.

Appendix E lists other relevant demographic data. Comparative charts of subjects' age, race, educational level, and employment status are included in that appendix.

Procedure.

A detailed description of the procedures used to secure subjects are included in Appendix A. A summary of the 75 potential subjects who were interviewed during their hospitalization for participation in this research follows (Table 2). Eleven percent (N=8) were unwilling to participate due to an inability to speak and/or read English, and three percent (N=2) were unwilling to participate due to undisclosed personal reasons.

Therefore, the final subject pool consisted of sixty-five primiparae, who agreed to participate in the study at the time of the initial telephone call following hospitalization. Fifty-four percent (N=35) of that group were lost due to attrition. Five percent (N=3) withdrew from the study upon receipt of the first questionnaire. Of those three subjects, two stated that they were too busy with the baby to find time to fill out the questionnaire and the third stated that she was too busy due to a move into a new home. Of the remaining thirty-two lost subjects, twenty-eight percent (N=18) withdrew by not returning the

first questionnaire at one month postpartum, despite a stated willingess to do so during follow-up telephone calls. A survey of these subjects elicited two primary explanations of "just too busy" to get to it and/or "just forgot" to do it. Eighteen percent (N=12) of the sample withdrew by not returning the second questionnaire at two months postpartum, despite a stated willingness in two follow-up telephone calls to do so. The investigator did not survey this group in any more detail as she did not want to appear to be putting pressure on these individuals. Finally, three percent (N=2) returned two questionnaires and not the third. It is unclear as to the reasons as each subject had agreed to return the questionnaire. In summary-, forty-six percent of the original pool of subjects completed all three questionnaires, leaving a sample size of thirty (N=30).

Instrumentation

The variables examined in this research were the difficulty of the transition to parenthood measured by the Transition Difficulty (Steffensmeier, 1977), perceived social support measured by The Social Provisions Scale (Russell & Cutrona, 1984), locus of control measured by The Internal-External Scale (Rotter, 1966), and depression measured by the short form of the Multiscore Depression Inventory (SMDI; Berndt, Berndt, & Kaiser, 1984). Each

variable was assessed at three points in time at 1 month, 2 months, and 5 months postpartum.

The Transition Difficulty. The Transition Difficulty is an empirical measure designed by Steffensmeier (1977) to assess both the objective and subjective impact of the transition to parenthood on first-time parents. This includes the effects of the birth of the first child upon parents' lifestyle and the parents' subjective perceptions of those effects, and the positive aspects of parenthood.

The Transition Difficulty is a 25-item inventory developed for an interview format. For purposes of the current research, the instrument was adapted from an interview format to a self-administered, paper and pencil inventory. The adaptation included a rewording of the directions to elicit written responses. In addition, changes were made in the wording of a number of individual items to reflect an orientation towards mothers rather than parents in general. For example, "worry about being a good parent" was modified to read "worry about being a good mother." Completion time for the adapted measure approximated a range of 5 to 15 minutes.

Detailed instructions for scoring the measure are included in Appendix A.

The dimensions of transition difficulty values are interpreted in the following directions (Steffensmeier,

1990). The higher the parental gratifications (PG) dimension score, the greater the rewards in the parenthood role and self-concept; the higher the parental responsibilities and restrictions (PRR) score, the greater the negative effects of parenthood upon one's lifetyle; and the higher the marital intimacy and stability (MIS) subscale score, the greater the concerns regarding the maintenance of the companionable aspects of the marital relationship.

The three dimensions or factors in transition difficulty were found to correlate only slightly. Correlations between the factors were as follows: between PRR and PG was -.12; between PRR and MIS was -.19; and between PG and MIS was .16. A factor analysis of the measure revealed that all but four of the twenty-five items clearly loaded on one of the three factors. Of the four ambiguously loaded items, "three are ranked at or near the bottom of the factor and thus not of major importance in defining the factors" (Steffensmeier, 1977).

This measure has yielded reliability estimates for the types of transition difficulty. The internal consistency (coefficient alpha) was .75 for parental responsibilities and restrictions; .82 for parental gratifications; and .76 for marital intimacy and stability (Steffensmeier, 1977).

Social Provisions Scale. The Social Provisions Scale is designed to measure the degree to which social

relationships supply each of six relational provisions (Russell & Cutrona, 1984). The Social Provisions Scale was based on Weiss' (1973) model of the role and function of social supports, such that, the scale measures the relational assets supplied to an individual by current social relationships. The Social Provisions Scale is derived from the following relational assets, which comprise the measure's six subscales: 1) Attachment, 2) Social Integration, 3) Opportunity for Nurturance, 4) Reassurance of Worth, 5) Reliable Alliance, and 6) Guidance. The Attachment subscale assesses the individual's sense of security and safety. The Social Integration subscale assesses the network of relationships with which the individual can share interests and concerns. The Nurturance subscale assesses the individual's opportunity to care for and provide for the well-being of another person. The Reassurance of Worth subscale assesses the individual's sense that his/her abilities are acknowledged and valued. The Reliable Alliance subscale assesses the degree of practical assistance that is available to the individual under any circumstances. The Guidance subscale assesses the individual's sense that trustworthy and authoritative persons, who can give meaningful advice, are available.

The Social Provisions Scale is a 24 item, self-administered questionnaire. It has an approximate

completion time of 5 - 15 minutes. The Social Provisions Scale (Russell & Cutrona, 1984) asks respondents to rate the degree to which their social relationships supply each of six relational subscales: 1) attachment, 2) social integration, 3) opportunity for nurturance, 4) reassurance of worth, 5) reliable alliance, and 6) guidance. Each of the subscales consists of four items, two which describe the presence of the provision and two which describe the absence of the provision. The scale is tabulated by firstly, inverting the scores of the items which describe the absence of the social provision and then summing all four subscale items. The score is interpreted such that a high score indicates the respondent is receiving that provision from his or her current social relationships. A total social support score is also obtained by summing the six individual provision scores.

Russell and Cutrona (1984) report that the scale has a high internal consistency (Cronbach alpha = .84). Reliability estimates (coefficient alpha) for each of the social provisions range from .33 to .56, with a mean of .49. Construct validity of the Social Provisions Scale as an index of social support has been established through several studies. Cutrona (1982) found a relationship between the six social provisions and the UCLA Loneliness Scale in college students; in which the social provisions accounted

for sixty-six percent of the variance in scores on the loneliness scale. In a sample of elderly subjects, the total scale score correlated from .28 to .31 with life satisfaction, loneliness and depression (Cutrona, et al., 1984). Russell, et al., (1984) reported that the individual provisions correlated with different relationship ratings in a study of college students. For example, social integration correlated with perceived quality of friendships ($r = .69$), and attachment correlated with satisfaction with romantic or marital relationship ($r = .53$). Intercorrelations among the six individual provisions range between .10 and .51, with a mean intercorrelation of .27.

Internality - Externality Scale (I - E Scale). The I-E Scale is designed to measure locus of control which is defined as the generalized expectancy or belief in external versus internal control of reinforcement (Rotter, 1966). The I-E Scale was based on social learning theory, in which reinforcement is viewed as strengthening beliefs or expectancies that events or behaviors will be followed by that reinforcement in the future (Rotter, 1966). Therefore, the I-E Scale measures the individual's belief or expectancy about how reinforcement is controlled.

The I-E Scale is a 29 item, forced-choice, self-administered questionnaire, which includes 6 filler items intended to disguise the purpose of the test. The

measure has an approximate completion time of 5 - 15 minutes. Scoring the I-E Scale requires summing the external responses, less the 6 filler items. The score is the total number of external choices.

Rotter (1966) reports that the I-E Scale has an only moderately high internal consistency (Spearman-Brown split half correlation = .73). However, Rotter (1966) suggests that this estimate reflects the fact that the items are not arranged in a hierarchical order of difficulty and that the test is additive and the items are not comparable. Therefore, the estimates of internal consistency tend to be underestimated.

Test-retest reliability at one month was relatively consistent in two different samples with .72 for a group of college students and .78 for a group of prison inmates. A two month test-retest reliability measure showed a typical drop of one point in the direction of less externality. Rotter (1966) suggests that the test conditions for the two month retest were changed from group setting to an individual administration which may have effected the results. A median correlation of -.22 was found with the Marlowe-Crown Social Desirability Scale for a number of college student samples. Rotter (1966) also reports that low relationships to intelligence, social desirability, and political liberalness demonstrate discriminant validity.

The Multiscore Depression Inventory (SMDI). The SMDI is the short form of the Multiscore Depression Inventory (MDI; Berndt, Petzel, & Berndt, 1980). Both instruments are designed to measure the severity of depressive symptoms with subclinical and normal populations (Berndt, Berndt, & Kaiser, 1984). A factor analysis of the SMDI revealed the following nine main subscales: Social Introversion, Guilt, Cognitive Difficulty, Pessimism, Irritability, Energy Level (low), Sad Mood, Self-esteem (low), and Helplessness. All of the subscales except for Helplessness reflect common depressive symptoms. Helplessness refers to an active attempt to elicit help or sympathy from others. Each of the subscales consist of four to six true-false items.

The SMDI is a 47-item, self-administered questionnaire. It has an approximate completion time of 5 - 10 minutes.

This measure has yielded reliability estimates of subscales' internal consistency, ranging in the .70s and .80s (coefficient alpha). The total score range was between .92 and .88. Test-retest reliability of immediate and three week intervals were in the .70s and .80 for all subscales except irritability. Irritability appears to be a more transient measure than the other subscales.

When the full scale score was not corrected by removing the items in the short form, the SMDI correlated with the full MDI in the high .80s and .90s (Berndt, et al., 1984).

The total score for the SMDI and MDI correlated adequately (r = .91). All correlations were highly significant (p .001).

Demographic Questionnaire. In order to better describe the subjects in this study, the investigator designed an 8 item, self-administered demographic questionnaire. The questionnaire assessed the following areas: age, racial background, educational level, marital status, length of time of marriage, employment status, type of employment, and household income category.

Design and Statistical Analysis

The present investigation is considered descriptive research as no variables were manipulated. A "longitudinal time" design (Kerlinger, 1973) was employed to assess and analyze developmental change in the dependent and independent variables over the first five months of postpartum and to examine the relationship between the variables as well. Therefore, a group of subjects (N=30) completed four questionnaires at three points in time; at one, two and five months postpartum.

The psychometric instruments that were utilized measured the variables of transition difficulty, social support provisions, locus of control and depression. A relationship between postpartum and depression has been well established in the literature (Kruckmann, 1976), however, it

was included in this study and this analysis not as an interest in psychopathology but as a means of tracking emotional adjustment.

One way analyses of variance were repeated to asess developmental change in the dependent and independent variables over time. Pearson Product correlations were performed to analyze the relationship among the dimensions of transition difficulty and the independent variables and the social support and depression subscales. A correlation was also utilized to examine the relationship between transition difficulty and social support with the variance due to nurturance removed. The level of significance for all statistical procedures was the .05 level.

CHAPTER IV

PRESENTATION AND ANALYSIS OF THE DATA

Overview

This chapter presents and summarizes the findings of this investigation. Preliminary statistical analyses were performed to assess the representativeness of the sample. Supplemental analyses were performed to clarify and amplify these findings. Results are presented in tabular form as appropriate. The sample in this investigation was composed of a group of thirty primiparous subjects (N=30), who were assessed at three points in time: Time 1 at one month postpartum, Time 2 at two months postpartum, and Time 3 at five months postpartum.

The chapter consists of six sections. The first compares the three dimensions of transition difficulty, which is the dependent variable, across time. These dimensions include parental gratifications (PG); parental responsibilities and restrictions (PRR); and marital intimacy and stability (MIS). Sections two and three compare social support and locus of control, which are the independent variables, across time. The fourth and fifth sections discuss the relationship between the dimensions of transition difficulty and social support and locus of control across time. Section six discusses supplemental

post hoc analyses which compared a depression screening measure and its subscales across time and examined the relationship between non-clinical depression symptomology and both the dependent and independent variables.

In addition, t-tests were utilized to examine the sample of subjects that completed the study (N=30) in contrast to a sample of subjects that was assessed at Time 1 only (N=11) but did not complete the study (See Appendix C). The t-tests revealed no significant difference between the two samples at Time 1. This finding suggests that the mothers who responded to the questionnaire at Time 1 only were not substantially different from mothers, who completed all three questionnaires, in regard to the variables of interest in this study.

Section I: Hypothesis I

Hypothesis One: There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for each dimension of transition difficulty.

The difficulty of the transition to parenthood during early postpartum was assessed by the Transition Difficulty measure, which has separate scales for each of its three dimensions: parental gratifications (PG), parental responsibilities and restrictions (PRR), and marital intimacy and stability (MIS). Table 1 summarizes the repeated measures MANOVA performed on the three dimensions of transition difficulty and the independent variables,

Table 1

One Way Analyses of Variance Involving Major Independent and Dependent Variables: Time 1, 2, and 3

Variable	F	p	Interpretation
Parental Gratifications	1.017	.368	n.s.
Parental Responsibilities and Restrictions	4.095	.021	The negative impact of a child's birth upon a primipara's lifestyle decreases from the first to the fifth month postpartum.
Marital Intimacy and Stability	.314	.731	n.s.
Social Support	.768	.469	n.s.
Locus of Control	1.340	.269	n.s.

Significance at .05 level

social support and locus of control. The results reveal a significant difference across time in only one of the transition difficulty dimensions, parental responsibilities and restrictions (PRR).

Tables 2 and 3 present the means and standard deviations for PRR, and demonstrate a significant decrease in parental responsibilities and restrictions across time. This finding suggests that the negative impact of the birth of the first child upon a mothers' lifestyle at one month postpartum lessens significantly from two to five months postpartum.

Table 4 presents the means and standard deviations for each of the eight PRR items across time. An ad hoc test (MANOVA) was performed on the eight PRR items to determine the source of the variance on this dimension between Time 1, 2, and 3. Table 5 illustrates the two items which accounted for the variance in parental responsibilities and restrictions: "bothered by loss of sleep", and "bothered by not being able to get out of the house during the day". An additional item, "worried about being a good mother", approached but did not reach signficance.

These results suggest that the bother associated with parental responsibilities and restrictions during the first months of postpartum lessens over time as the new mother either adapts to the loss of sleep and to the restrictions in getting out of the house during the day, or the amount of

Table 2

Means and Standard Deviations of Parental Restrictions and Responsibilities (PRR) Across Time

N=30	Mean	Standard Deviation
Time 1	21.30	2.69
Time 2	19.93	2.77
Time 3	19.86	3.22

Table 3

One Way ANOVA Test of Parental Restrictions and Responsibilities (PRR) Across Time

Source	DF	SS	MS	F	P
Between	29	457.56	15.77	4.09	.02
Within	60	317.33	5.28		
Total	89	774.90	8.70		

Table 4

Ad Hoc Means and Standard Deviations of Eight Items Comprising Parental Restrictions and Responsibilities (PRR) Across Time

Items	Time 1		Time 2		Time 3	
	X	SD	X	SD	X	SD
Worries						
1. being good mother	2.46	1.00	2.23	.81	2.10	.99
2. added responsibility	2.53	.86	2.33	.84	2.60	.96
Changes						
13. socializing with friends	2.86	.89	2.93	.82	3.16	.79
15. not getting out with spouse	3.56	.81	3.36	.80	3.66	.71
27. regularity activities	3.46	1.00	3.23	.89	2.96	1.12
Bothers						
28. loss of sleep	2.43	.62	2.13	.62	1.80	.66
29. interruptions by baby	1.90	.66	1.86	.62	1.86	.50
30. not getting out during day	2.06	.58	1.83	.59	1.70	.53

Key: X = mean
SD = standard deviation

Table 5

Ad Hoc One Way ANOVA Test of Eight Items Comprising Parental Restrictions and Responsibilities (PRR) Across Time

Items	F	p
Worries		
1.being good mother	3.00	.057
2.added responsibility	1.46	.239
Changes		
13.socializing with friends	1.81	.172
15.not getting out with spouse	1.97	.148
27.regularity activities	2.84	.066
Bothers		
28.loss of sleep	13.81	.000*
29.interruptions by baby	.04	.952
30.not getting out during day	4.51	.015*

*$p < .05$

sleep and getting out of the house increases after the first month postpartum, which mitigates the "bother."

Referring again to Table 1, the results of the repeated measures MANOVA for the PG and the MIS dimensions of transition difficulty reveal no significant differences in either parental gratifications or marital intimacy and stability across time. These findings indicate no change in either the rewards of parenthood or the concerns in maintaining the companionable aspects of the marital relationship during the early months of postpartum. (See Appendix G, Tables I and II for means, standard deviations, and MANOVA results for PG and MIS.)

Therefore, due to the statistical findings, the null hypothesis for two of the dimensions of transition difficulty, parental gratifications (PG) and marital intimacy and stability (MIS) failed to be rejected as they demonstrate no significant difference across time. However, the null hypothesis is rejected for the parental responsibilities and restrictions (PRR) dimension of transition difficulty as there was a significant decrease in this variable across time.

Section II: Hypothesis II

Hypothesis Two: There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for social support.

Social support, which is one of the major independent variables identified in this research, was assessed by the Social Provision Scale. This instrument provides a total social support score and six subscale scores. These subscales reflect the individual relational assets that social relationships provide: reliable alliance reflects the degree of practical assistance that is available to an individual under any circumstances; attachment reflects a sense of security and safety; guidance reflects the availability of trustworthy and authoritative individuals, who can give meaningful advice; nurturance reflects opportunities to care and provide for the well-being of another; social integration reflects a network of relationships with which one can share interests and concerns; and reassurance of worth reflects the acknowledgement and valuing of one's abilities by others.

A one way analysis of variance of repeated measures (MANOVA) was performed on social support including its subscales. As reported in Table 1, there is no significant difference in total social support between Time 1, 2, and 3. Additional one way analyses of variance for repeated measures were performed on each of the six individual social provisions subscales. The results of these analyses as reported in Table 6 demonstrate no significant difference across time for any of the social support subscales.

Table 6

One Way Analyses of Variance Involving Social Provisions Subscale Scores

Variable	F	p	Interpretation
Reliable Alliance	1.177	.315	n.s.
Attachment	.538	.586	n.s.
Guidance	.499	.609	n.s.
Nurturance	.763	.470	n.s.
Social Integration	.021	.978	n.s.
Reassurance of Worth	.943	.395	n.s.

These findings suggest that primiparae experience no difference in either the total amount of social provisions or the degree of social relational assets over the course of the first five months of postpartum. Therefore, the quality of social support in this population appears to remain largely unchanged throughout the first months of postpartum. For lack of evidence, the null hypothesis of no significant difference in total social support or individual social provisions failed to be rejected.

Section III: Hypothesis III

Hypothesis Three: There is no significant difference between measurement 1, 2, and 3 (e.g. Time 1, Time 2, and Time 3) for locus of control.

Locus of control, defined as a generalized expectancy or belief that events or behaviors will or will not be followed by a reinforcement, was assessed by the I - E Scale (Internality - Externality). An "external" locus of control views consequences as determined by forces outside the self; or an "internal" locus of control views consequences as the result of individual behavior. As such, locus of control is conceptualized as a personality trait, which by definition is a relatively stable characteristic and is not expected to vary. However, for purposes of this study, it was hypothesized that locus of control might fluctuate during postpartum, given the potential changes in lifestyle, social

role and self-concept which the birth of the first child engenders.

Table 7

Means and Standard Deviations of Locus of Control Across Time

N=30	Mean	Standard Deviation
Time 1	9.50	3.56
Time 2	9.80	3.82
Time 3	9.03	3.95

Table 7 presents the external locus of control means and standard deviations for this sample. These scores are contrast to the normative mean of 8.0 (Rotter, 1966), which indicates that this sample is more externally-oriented than the normative samples were on this measure.

Table 8 presents the one way analysis of variance of repeated measures (MANOVA) for locus of control, which reveals no significant difference between Time 1, 2, and 3.

Table 8

One Way ANOVA Test of Locus of Control Across Time

Source	DF	SS	MS	F	P
Between	29	1053.55	36.32	1.34	.26
Within	60	202.66	3.37		
Total	89	1256.22	14.11		

These findings suggest that locus of control does not fluctuate during the postpartum despite transition to parenthood.

Due to a lack of evidence, therefore, the null hypothesis, of no significant difference in locus of control across time, failed to be rejected.

Section IV: Hypothesis IV

Hypothesis Four: There is no relationship between transition difficulty and social support.

Pearson correlation coefficients were utilized to assess the relationship between each of the three dimensions of transition difficulty (PG, PRR, and MIS) and social support, including its subscales. Table 9 summarizes the results for total social support

Table 9

Correlations Between Transition Difficulty and Independent Variables at Time 1, Time 2, and Time 3

Variable	Social Support (Total)	Locus of Control E	Locus of Control I
Time 1			
PG	.008	-.198	.198
MIS	-.080	.005	-.005
PRR	-.040	.095	-.095
Time 2			
PG	.119	-.023	.023
MIS	-.103	-.139	.139
PRR	.057	.180	-.180
Time 3			
PG	.100	-.319	.319
MIS	-.312	.320	-.320
PRR	-.102	.235	-.235

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilities and restrictions
E = external locus of control
I = internal locus of control

*$p < .05$

No significant correlations were found between total social support and the dimensions of transition difficulty across time. These results suggest little association between social support and parental gratifications, parental restrictions and limitations, or marital intimacy and stability during the first five months of postpartum.

The next step was to determine whether an interaction between the variables might account for the lack of significant main effects. Therefore, a one way analysis of repeated measures (MANOVA) was performed, using a median split for the social support variable (high/low). The interaction between time, transition difficulty, and high or low social support was not significant for any of the three dimensions of transition difficulty: PG is $F(2, 56) = .92$, $p < .666$; PRR is $F(2,56) = .16$, $p < .850$; and is MIS, $F(2,56) = .85$, $p < .435$.

Additional pearson product correlations were performed to assess the relationship between the dimensions of transition difficulty and the social support subscales. (See Tables 10, 11, 12.) Only one significant negative correlation was found between MIS and guidance at Time 3, $-.431$, $p < .017$. This finding suggests an inverse relationship at five months postpartum between marital intimacy and stability and the the availability of

Table 10

Correlations Between Dimensions of Transition Difficulty and Social Support Subscales - Time 1

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
PG	.015	.125	.047	-.144	.119	-.127
PRR	.192	.048	-.191	.200	-.260	-.162
MIS	-.225	-.133	-.137	.191	-.060	.019

Key: PG = Parental Gratifications
PRR = Parental Responsibilities and Restrictions
MIS = Marital Intimacy and Stability

REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NURTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

*$p < .05$

Table 11

Correlations Between Dimensions of Transition Difficulty and Social Support Subscales - Time 2

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
PG	.269	.120	.193	.133	.018	-.092
PRR	.097	.180	-.054	-.060	.071	.065
MIS	-.225	-.072	-.153	-.016	-.056	-.017

Key: PG = Parental Gratifications
PRR = Parental Responsibilities and Restrictions
MIS = Marital Intimacy and Stability

REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NURTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

*$p < .05$

Table 12

Correlations Between Dimensions of Transition Difficulty and Social Support Subscales - Time 3

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
PG	.023	.056	.030	.139	.131	.151
PRR	-.190	-.034	-.240	-.145	.044	.046
MIS	-.207	-.268	-.431	-.205	-.292	-.203

Key: PG = Parental Gratifications
PRR = Parental Responsibilities and Restrictions
MIS = Marital Intimacy and Stability

REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NURTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

*$p < .05$

authoritative individuals who can give advice and guidance.

Therefore, except for this correlation, these findings provide evidence that the hypothesis of no significant relationship between total social support including its subscales and the PG, PRR, and MIS dimensions of transition difficulty failed to be rejected.

Section V: Hypothesis V

Hypothesis Five: There is no significant relationship between transition difficulty and locus of control.

As reported in Table 9, pearson correlation coefficients were performed for each point in time on the three dimensions of transition difficulty and locus of control. The correlations between an external locus of control, a belief system which posits consequences as outside of one's control, and each of the dimensions of transition difficulty (PG, PRR, and MIS) are not significant. These findings suggest that during the first five months of postpartum, locus of control has little relationship to the positive rewards or gratifications of parenthood; to the negative aspects of lifestyle changes; or to the concerns regarding the maintanence of the companionable aspects of the marital relationship that mothers' report in the first five months of the postpartum transition to parenthood. Therefore, due to these results, the hypothesis of no significant relationship between locus of control and the PG, PRR, and MIS dimensions of transition

difficulty failed to be rejected.

Section Six: Supplementary Analyses

Post Hoc Analyses of Depression

The symptomology of depression in a non-clinical population, as measured by the Short Form of the Multiscore Depression Inventory (SMDI), was also examined in this study. Post hoc one way analysis of variance of repeated measures (MANOVA) were performed to assess change across time. In addition, pearson correlation coefficients were performed tc detect relationships among total depression and individual symptoms of depression and the dimensions of transition difficulty; social support; and locus of control.

The results of the MANOVA, as presented in Table 13, demonstrate no significant difference across time in total depression or individual depressive symptoms. The findings suggest that overall depression and individual depressive symptomology do not change significantly for new mothers who experience them during the first five months of postpartum. (See Appendix G, IX - XVII.)

Pearson correlation coefficients were performed tc assess relationships between total depression, its symptomology subscales and the three dimensions of transition difficulty, social support, and locus of control across time.

Table 13

One Way Analyses of Variance Involving Total Depression and Depression Subscale Scores

Variable	F	p	Interpretation
Total Depression	.285	.752	n.s.
Cognitive Difficulty	.397	.673	n.s.
Energy Level	.576	.565	n.s.
Self Esteem	.405	.668	n.s.
Guilt	2.194	.120	n.s.
Social Introversion	.155	.856	n.s.
Pessimism	.398	.673	n.s.
Irritability	.729	.486	n.s.
Sad Mood	.391	.677	n.s.
Helplessness	.953	.391	n.s.

Tables 14 - 16 illustrate no significant correlations between total depression and the dimensions of transition difficulty: PG, PRR, and MIS. These results suggest that parental gratifications, parental responsibilities and restrictions, and marital intimacy and stability do not appear to be related to total depression in this sample at any of the three points in time.

Correlations between the individual depression subscales and the dimensions of transition difficulty across time are also presented. Table 14 demonstrates no significant correlations at Time 1 between individual depressive symptoms and any of the three dimensions of transition difficulty. At Time 2 as illustrated by Table 15, a significant correlation between irritability and MIS suggests that irritability in primiparae at two months postpartum is related to increased concerns regarding the maintenance of the companionable aspects of the marital relationship. Table 16 demonstrates a significant negative correlation between pessimism and PG at Time 3, which implies an inverse relationship between pessimism in primiparae at five months postpartum and rewards in the parenthood role. A significant correlation at Time 3 between social introversion and MIS indicates that difficulties with social introversion in primiparae at five months postpartum is positively related to concerns

Table 14

Correlations Between Total Depression and Depression Subscales and Dimensions of Transition Difficulty - Time 1

Variable	PG	MIS	PRR
Total Depression	.244	.244	.291
Cognitive Difficulty	.325	.151	.154
Energy Level	.111	-.001	.288
Self Esteem	.108	.272	-.023
Guilt	.284	.137	.139
Social Introversion	.031	-.277	.168
Pessimism	-.236	.256	.140
Irritability	-.043	.348*	.220
Sad Mood	.107	.144	.242
Helplessness	.250	.193	-.027

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilites and restrictions

*$p < .05$

Table 15

Correlations Between Total Depression and Depression Subscales and Dimensions of Transition Difficulty - Time 2

Variable	PG	MIS	PRR
Total Depression	.077	.084	.297
Cognitive Difficulty	.084	.071	.082
Energy Level	.070	.016	.305
Self Esteem	.054	-.017	.059
Guilt	.061	-.059	.354
Social Introversion	-.083	.058	.256
Pessimism	.092	-.009	-.039
Irritability	-.043	.483*	.126
Sad Mood	.138	-.037	.249
Helplessness	.015	.054	.024

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilities and restrictions

*$p < .05$

Table 16

Correlations Between Total Depression and Depression Subscales and Dimensions of Transition Difficulty - Time 3

Variable	PG	MIS	PRR
Total Depression	-.260	.238	.185
Cognitive Difficulty	-.089	.116	.025
Energy Level	-.243	.049	.030
Self Esteem	-.270	.308	.154
Guilt	.057	.035	.256
Social Introversion	-.317	.382*	.162
Pessimism	-.433*	.224	.121
Irritability	-.145	.222	.107
Sad Mood	.015	.082	.244
Helplessness	-.224	.193	.096

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilites and restrictions

*$p < .05$

regarding the maintenance of the companionable aspects of the marital relationship.

Post hoc analyses were performed to examine the relationship between total depression and total social support, defined as the social provisions or relational assets which social relationships provide. Significant negative correlations between depression and total social support at Time 1 and at Time 3 indicate an association between depressive symptoms at one month and five months postpartum and fewer available social provisions.

In addition, as reported in Table 17, a number of significant negative correlations were found at each point in time between total social support and individual depressive symptoms. Significant negative findings indicate inverse relationships between total social support and low self-esteem at Time 1 (one month postpartum); between total social support and sad mood at Time 2 (two months postpartum); and between total social support and fatigue, guilt, pessimism, and helplessness at Time 3 (five months postpartum).

Additional pearson correlation coefficients examined the relationship between the social provisions subscales and the depression subscales. Table 18 presents the results of those analyses at Time 1, one month postpartum. Significant

Table 17

Post Hoc Correlations Between Total Depression, Depression Subscales, and Total Social Support Across Time

Variable	Total Social Support		
	Time 1	Time 2	Time 3
Total Depression	-.391*	-.282	-.499*
Cognitive Difficulty	-.258	-.172	-.150
Energy Level	.285	.067	-.521*
Self Esteem	-.412*	-.352	-.358
Guilt	-.163	-.179	-.433*
Social Introversion	-.147	-.168	-.072
Pessimism	-.259	-.181	-.417*
Irritability	.039	-.044	-.122
Sad Mood	-.076	-.388*	-.183
Helplessness	-.290	-.313	-.596*

*$p < .05$

negative correlations were found between the social provision, reliable alliance and the depressive symptoms of self esteem and helplessness, which suggest an inverse relationship between availability of practical assistance and low self esteem and feeling helpless. A significant negative correlation between the social provision, social integration and the depressive symptom, helplessness, suggests an inverse relationship between having a network of relationships with which one shares interests and concerns and feeling helpless. Significant negative correlations between the social provision, reassurance of worth and the depressive symptoms of cognitive difficulty and energy level suggest an inverse relationship between feeling acknowledged and valued and symptoms of fatigue and difficulty thinking clearly.

Table 19 presents the results of correlations between the social provision subscales and depression subscales at Time 2, two months postpartum. Significant negative correlations were found between the social provision of attachment and the depressive symptoms of self esteem and helplessness, which indicate inverse relationships between a sense of safety and security and low self esteem and helplessness. Significant negative correlations between the social provisions of guidance and social intergration, and

Table 18

Correlations Between Depression Subscales and Social Support Subscales - Time 1

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
Cog Diff	-.245	-.139	-.121	-.137	-.156	-.395*
Ener Lev	-.135	-.188	-.223	-.042	-.327	-.400*
Self Estm	-.377*	-.275	-.296	-.300	-.300	-.353
Guilt	-.290	-.067	-.086	-.053	-.135	-.123
Soc Intro	-.056	-.121	-.232	.017	-.210	-.062
Pess	-.288	-.240	.196	-.156	.156	-.155
Irrit	.180	.041	-.014	.153	-.090	-.084
Sad	.024	-.024	-.021	.020	-.094*	-.262
Help	-.490*	-.278	.012	.091	-.387*	-.313

Key: REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NUTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

Cog Dif = Cognitive
Self Est = Self Esteem
Soc Intr = Social Introversion
Irrit = Irritability
Help = Helplessness
Ener Lev = Energy Level
Guilt = Guilt
Pess = Pessimism
Sad = Sad Mood

*$p < .05$

Table 19

Correlations Between Depression Subscales and Social Support Subscales - Time 2

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
Cog Diff	-.226	-.234	-.228	.242	-.242	-.178
Ener Lev	.094	.076	.062	.097	.068	-.035
Self Estm	-.322	-.424*	-.332	-.119	-.275	-.388*
Guilt	-.133	-.270	-.257	.123	-.164	-.234
Soc Intro	-.078	-.255	-.122	-.322	-.090	-.059
Pess	-.178	-.298	-.092	-.134	-.083	-.180
Irrit	-.002	-.116	-.094	-.180	.029	.101
Sad	-.220	-.336	-.406*	-.278	-.385*	-.441*
Help	-.335	-.471*	-.309	-.048	-.172	-.320

Key:
REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NUTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

Cog Dif = Cognitive
Self Est = Self Esteem
Soc Intr = Social Introversion
Irrit = Irritability
Help = Helplessness
Ener Lev = Energy Level
Guilt = Guilt
Pess = Pessimism
Sad = Sad Mood

*$p < .05$

Table 20

Correlations Between Depression Subscales and Social Support Subscales - Time 3

Variable	REALL	ATTACH	GUID	NUTR	SOCIN	REWORT
Cog Diff	-.259	-.287	-.071	.152	-.179	-.067
Ener Lev	-.578*	-.574*	-.290	-.352	-.452*	-.394*
Self Estm	-.388*	-.494*	-.283	-.105	-.251	-.265
Guilt	-.480*	-.516*	-.306	.115	-.366*	-.389*
Soc Intro	-.063	-.094	-.070	-.116	-.080	-.052
Pess	-.371*	-.391*	-.402*	-.348	-.252	-.372*
Irrit	-.236	-.191	-.081	-.054	-.099	.066
Sad	-.283	-.296	-.093	-.022	-.102	-.136
Help	-.622*	-.706*	-.460*	-.231	-.521*	-.463*

Key:
REALL = Reliable Alliance
ATTACH = Attachment
GUID = Guidance
NUTR = Nurturance
SOCIN = Social Integration
REWORT = Reassurance of Worth

Cog Dif = Cognitive
Self Est = Self Esteem
Soc Intr = Social Introversion
Irrit = Irritability
Help = Helplessness
Ener Lev = Energy Level
Guilt = Guilt
Pess = Pessimism
Sad = Sad Mood

*$p < .05$

the depressive symptom, sad mood, indicate an inverse relationship between the relational assets of having authoritative individuals available who can provide guidance and feeling part of a social network with whom one shares interests and concerns and the symptom of sadness. Finally, significant negative correlations at Time 2 between the social provision of reassurance of worth and depressive symptoms of self esteem and sad mood suggest an inverse relationship between feeling one's abilities are valued and acknowledged and low self esteem and sadness.

Table 20 illustrates a number of significant correlations at Time 3, five months postpartum. Signficant negative correlations were found between two social support subscales, reliable alliance and attachment which represent practical assistance and a sense of security and safety, and depressive symptoms of fatigue, low self esteem, guilt, pessimism, and helplessness. Significant negative correlations were also found between the social support subscale of guidance and depressive symptoms of pessimism and helplessness. Finally, signficant negative correlations were found at Time 3 between the social support subscale, social integration, which reflects a network of relationships with which to share interests and concerns, and depressive symptoms of low self esteem, guilt, and helplessness.

The variable of locus of control was also examined in relationship to the depressive symptomology. The data is presented in the context of an "external" locus of control, defined as the generalized belief system that consequences are the result of forces outside of one's behavior. Table summarizes the results of pearson product correlations performed on external locus of control and the depression subscales across time. The analyses demonstrate a number of significant correlations. These correlations, all in a positive direction, suggest that an external locus of control is associated with more guilt and pessimism at Time 1, one month postpartum; more fatigue at Time 2, two months postpartum; and greater pessimism and difficulties with self esteem at Time 3, five months postpartum.

In summary, the focus of this investigation has been on a normal population and non-clinical depressive symptomology. A number of associations between an external locus of control and depressive symptomology were found. These findings support previous research which has indicated that individuals with an external locus of control, in contrast to an internal locus of control, appear to

Table 21

Post Hoc Correlations Between Total Depression, Depression Subscales, and Locus of Control Across Time

Variable	Locus of Control					
	Time 1		Time 2		Time 3	
	E	I	E	I	E	I
Total Depression	.330	-.330	.242	-.242	.374*	-.374*
Cognitive Difficulty	.175	-.175	.059	-.059	.198	-.198
Energy Level	.264	-.264	.384*	-.384*	.295	-.295
Self Esteem	.283	-.283	.114	-.114	.370*	-.370*
Guilt	.413*	-.413*	.324	-.324	.312	-.312
Social Introversion	.071	-.071	.043	-.043	.171	-.171
Pessimism	.369*	-.369*	.151	-.151	.456*	-.456*
Irritability	-.187	.187	-.284	.284	.180	-.180
Sad Mood	-.047	.047	.154	-.154	.148	-.148
Helplessness	.083	-.083	.100	-.100	.249	-.249

Key: E = External locus of control
I = Internal locus of control

*$p < .05$

be more susceptible tc the negative effects of stressful life events as seen in greater psychological symptomology (Johnson & Saranson, 1978; Sandler and Lakey, 1982; Eckenrcde, 1983; Riley & Eckenrode, 1986).

Post Hoc Analyses of Demographic Data

Pearson correlation ccefficients between demographic data: education, income, and employment status; and the major dependent variable, dimensions of transition difficulty and the major independent variables of social support and locus of control across time are summarized in Tables 22 - 27.

Significant negative correlations between education and PRR at Time 1 and Time 2, as illustrated in Tables 22 and 23, imply an inverse relationship between educational level and parental responsibilities and restrictions reported during the first and second month of postpartum. Table 24 demonstrates that this association did not reach significance at Time 3 ($p < .051$) but may have proven statistically significant with a larger sample, N 30.

Post hoc correlations were utilized to examine education, income, and employment status in relationship to the social support subscales across time. As presented in Table 25, significant correlations were found at Time 1 between income and the social provisions of attachment, guidance, and nurturance.

Table 22

Correlations Between Transition Difficulty, Total Social Support, Locus of Control and Demographic Data at Time 1

Variable	Education	Income	Employment Status
PG	.025	.125	-.047
MIS	-.131	-.130	-.121
PRR	-.480*	-.056	.131
Tot Soc	.298	.434	.034
External	-.354	-.190	.130

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilities and restrictions
Tot Soc = Total Social Provisions
External = External Locus of Control

*$p < .05$

Table 23

Correlations Between Transition Difficulty, Total Social Support, Locus of Control and Demographic Data at Time 2

Variable	Education	Income	Employment Status
PG	-.015	.095	-.166
MIS	-.037	-.180	-.038
PRR	-.380*	-.184	-.111
Tot Soc	.222	.380	-.142
External	-.284	-.168	.102

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilities and restrictions
Tot Soc = Total Social Provisions
External = External Locus of Control

*$p < .05$

Table 24

Correlations Between Transition Difficulty, Total Social Support, Locus of Control and Demographic Data at Time 3

Variable	Education	Income	Employment Status
PG	.002	.034	-.126
MIS	-.230	-.260	.177
PRR	-.359*	-.163	-.095
Tot Soc	.440	.187	-.204
External	-.307	-.226	.115

Key: PG = parental gratifications
MIS = marital intimacy and stability
PRR = parental responsibilities and restrictions
Tot Soc = Total Social Provisions
External = External Locus of Control

*$p < .05$

Table 25

Correlations Between Social Provisions Subscales and Education, Income and Employment Status at Time 1

Variable	Education	Income	Employment Status
Reliable Alliance	.204	.224	.015
Attachment	.187	.366*	.095
Guidance	.259	.413*	.095
Nurturance	.239	.410*	.028
Social Integration	.181	.233	.091
Reassurance of Worth	.297	.345	.146

*p $<$ .05

Table 26 reports significant correlations at Time 2 between income and the social provisions of nurturance and social integration. Table 27 summarizes significate correlations at Time 3 between education and the social support provisions of reliable alliance, attachment, guidance, nurturance.

Post hoc correlation coefficients were performed on demographic data and total depression and depression subscales at each point in time. Table 28 summarizes the results for Time 1. Significant negative correlations indicate inverse associations between education and total depression and fatigue; and between employment status and sad mood. Table 29 reports no significant correlations at Time 2 between demographic data and depressive features. Table 30 presents results for Time 3. Significant negative correlations suggest inverse relationships between education and fatigue; and between income and cognitive difficulty.

Table 26

Correlations Between Social Provisions Subscales and Education, Income and Employment Status at Time 2

Variable	Education	Income	Employment Status
Reliable Alliance	.163	.223	-.263
Attachment	.223	.350	-.115
Guidance	.212	.326	-.065
Nurturance	.158	.458*	-.078
Social Integration	.199	.375*	-.159
Reassurance of Worth	.227	.309	-.065

*$p < .05$

Table 27

Correlations Between Social Provisions Subscales and Education, Income and Employment Status at Time 3

Variable	Education	Income	Employment Status
Reliable Alliance	.406*	.194	-.105
Attachment	.414*	.103	-.355
Guidance	.439*	.140	-.355
Nurturance	.385*	.262	-.052
Social Integration	.288	.148	-.133
Reassurance of Worth	.321	.125	-.113

*$p < .05$

Table 28

Post Hoc Correlations Between Demographic Data and Total Depression and Depression Subscales at Time 1

Variable	Education	Income	Employment Status
Total Depression	-.377*	-.161	-.106
Cognitive Difficulty	.414	.103	-.355
Energy Level	-.451*	-.079	.087
Self Esteem	-.326	-.027	-.092
Guilt	-.049	.007	.124
Social Introversion	-.026	-.174	.026
Pessimism	-.316	.021	.141
Irritability	.073	-.194	-.310
Sad Mood	-.185	-.213	-.415*
Helplessness	-.272	-.017	-.196

*$p < .05$

Table 29

Post Hoc Correlations Between Demographic Data and Total Depression and Depression Subscales at Time 2

Variable	Education	Income	Employment Status
Total Depression	-.265	-.087	-.212
Cognitive Difficulty	-.158	.039	-.114
Energy Level	-.145	.040	-.168
Self Esteem	-.179	.027	-.145
Guilt	-.213	-.124	-.039
Social Introversion	-.164	-.248	-.152
Pessimism	-.043	.007	-.170
Irritability	-.156	-.265	-.129
Sad Mood	-.212	-.079	-.269*
Helplessness	-.121	-.008	-.010

*$p < .05$

Table 30

Post Hoc Correlations Between Demographic Data and Total Depression and Depression Subscales at Time 3

Variable	Education	Income	Employment Status
Total Depression	-.271	.106	.009
Cognitive Difficulty	-.020	.430*	.114
Energy Level	-.388*	.013	-.057
Self Esteem	-.258	.059	-.044
Guilt	-.220	.107	-.031
Social Introversion	.044	-.294	.084
Pessimism	-.270	.138	.082
Irritability	.120	-.274	-.019
Sad Mood	-.142	-.020	-.225
Helplessness	-.292	.140	.029

*$p < .05$

CHAPTER V

SUMMARY

The Problem

Research on life crises and their impact on individuals and families, has stimulated interest in the factors which mediate the ensuing stress. Initially, the birth of the first child was viewed as an "expected" life crisis. However, developmental and family systems theorists redefined "expected" crises to normative life cycle transitions. Based on the assumption that normative implies a successful outcome or adjustment, life cycle transitions are viewed as stressful periods in which the intense adaptive process includes positive as well as negative aspects. The birth of the first child is just one of many life cycle transitions inherent to adult and family development.

The present study, based on developmental and family systems theory, focuses on the postpartum transition to parenthood as a normative, developmental experience. Therefore, the positive and negative aspects of this transition were assessed during the first five months

postpartum in order to measure developmental change.

Social support and individual differences, such as locus of control and socioeconomic status, are factors which have been found to mediate some reactions to the postpartum transition to parenthood. Therefore, in addition to assessing developmental change, this investigation examined the role of social support and individual differences in the adjustment process during the postpartum transition to parenthood.

Analysis of Results

Hypothesis One. Hypothesis One stated that there was no significant difference across time for each of the dimensions of transition difficulty. The only significant difference was found in the Parental Responsibilities and Restrictions (PRR) dimension of the Transition Difficulty measure, which suggests that the negative effects of a child's birth upon a primipara's lifestyle decrease from the first to the fifth month postpartum.

Hypothesis Two. Hypothesis Two stated that there was no significant difference across time for social support, as measured by the Social Provisions Scale. No significant differences were found during the first five months postpartum in total social support or in any of the social support subscales.

Hypothesis Three. Hypothesis Three stated that there was no significant difference across time for locus of control as measured by the I - E Scale. No signficant differences were found in either externality or internality during the first five months postpartum.

Hypothesis Four. Hypothesis Four stated that there was no significant relationship between the dimensions of transition difficulty and social support. One significant finding between the MIS dimension of transition difficulty, and the social support subscale, guidance, suggests a relationship between greater difficulties with marital intimacy and stability and less availability of authoritative individuals who can give new mothers advice and guidance.

Hypothesis Five. Hypothesis Five stated that there was no significant relationship between the dimensions of transition difficulty and locus of control. No significant relationships were found in this investigation.

Supplementary Analyses

Additional supplementary investigations were utilized to examine differences in depressive symptomology in a non-clinical population across time. Another area of investigation examined the relationships between depressive symptomology and the major variables of transition

difficulty, social support and locus of control and their subscales.

Depression and Transition Difficulty. There were no significant differences in total depression or individual depression subscales during the first five months of postpartum. An examination of the relationships between depression and transition difficulty revealed a significant association at two months postpartum (Time 2) between the depressive symptom of irritability in primipara and greater concerns regarding the intimacy and stability of the marital relationship. At five months postpartum (Time 3), the depressive symptom of pessimism was found to be related to fewer parental gratifications and the depressive symptom of social introversion was found to be related to greater concerns regarding the intimacy and stability of the marital relationship.

Depression and Social Support. An investigation of the relationships between total depression and total social support across time found that at one month postpartum (Time 1) and five months postpartum (Time 3) greater overall depression was related to less social support. An examination of the depression subscales and total social support revealed that at one month postpartum (Time 1), the depressive symptom of low self-esteem was related to less overall social support; at two months postpartum (Time 2),

the depressive symptom of sad mood was related to less overall social support; and at five months postpartum (Time 3), the depressive symptoms of low energy, guilt, pessimism and helplessness were related to less overall social support.

Additional investigations of the relationships between the depression subscales and social support subscales revealed a number of associations at one month postpartum (Time 1). For example, frequency of the depressive symptoms low self-esteem and helplessness were related to less reliable alliance, the social provisions which reflects the availability of consistant, practical assistance. The depressive symptom of helplessness was associated to less social integration, the social provision which reflects the network of relationships with which an individual shares interests and concerns. The depressive symptoms of cognitive difficulty and low energy level were associated with less reassurance of worth, the social provision which reflects one's feeling valued and acknowledged.

At two months postpartum (Time 2), depressive symptoms of low self-esteem and helplessness were related to less attachment, the social provision which reflects a sense of security and safety. The depressive symptom of sad mood was associated with less of the social provisions of guidance and social integration, which reflect the availability of

authoritative individuals who can give advice and feeling part of a social network with whom one shares interests and concerns. Finally, an association was found at Time 2 between the depressive symptoms low self-esteem and sad mood and less of the social provision, reassurance of worth, which reflects one's feeling valued and acknowledged.

At five months postpartum (Time 3), the depressive symptoms low energy, low self-esteem, guilt, pessimism and helplessness were related to less of the social provisions of reliable alliance and attachment, which reflect the availability of consistent, practical assistance and a sense of security and safety. The depressive symptoms of pessimism and helplessness were associated to less guidance, the social provision which reflects the availability of authoritative individuals who can give advice and guidance. Finally, at five months postpartum, depressive symptoms of low self-esteem, guilt and helplessness were related to less of the social provision social integration, which reflects a network of relationship with which one shares interests and concerns.

Depression and Locus of Control. In addition, supplementary investigations found relationships between depressive symptomology and an external locus of control. For example, an external locus of control was related to depressive symptoms of guilt and pessimism at one month

postpartum (Time 1); low energy at two months postpartum (Time 2); and low self-esteem and pessimism at five months postpartum (Time 3).

In summary, the results of this investigation suggest that only one major variable, parental responsibilities and restrictions, changed during the first five months postparum. The results were such, that: 1) of the three dimensions of Transition Difficulty only parental responsibilities and restrictions (PRR) decreased significantly from the first through the fifth month postpartum; parental gratifications (PR) and marital intimacy and stability (MIS) displayed no significant difference across time; 2) social support displayed no signficant difference across time; and 3) locus of control displayed no significant difference across time.

In addition, the results of this investigation suggest only one significant relationship between the major variables, marital intimacy and stability (MIS) and the social support subscale, guidance. Correlational analyses indicated an association between increased difficulties with marital intimacy and stability and less availability of authoritative individuals who can give advice and guidance. There were no other significant relationships between dimensions of transition difficulty, parental responsibilities and restrictions (PRR) and parental

gratifications (PG) and the variables of social support or locus of control.

In terms of the supplementary findings, neither total depression nor individual depression symptoms displayed a significant difference across time. However, a number of significant relationships were found between total depression and individual depressive symptoms and the major variables. In this regard: 1) at one month postpartum, greater total depression and self-esteem symptoms were associated with less overall social support; 2) at two months postpartum, irritability was associated with more marital intimacy and stability concerns (MIS); and sad mood was associated with less total social support; and 3) at five months postpartum, pessimism was associated with fewer parental gratifications (PG); social introversion was associated with more marital intimacy and stability concerns; and total depression, fatigue, guilt, pessimism, and helplessness were associated with less overall social support.

Significant relationships between the individual depression subscales and social support subscales were as follows: 1) at one month postpartum, low self-esteem and helplessness were related to less reliable alliance ; helplessness was also related to less social integration; and cognitive difficulty and fatigue were related to less

reassurance of worth; 2) at two months postpartum, low self-esteem and helplessness were related to less attachment; sad mood was related to less guidance and less social integration; low self-esteem and sad mood were related to less reassurance of worth; 3) at five months postpartum, fatigue, low self-esteem, guilt, pessimism and helplessness were related to less reliable alliance and less attachment; pessimism and helplessness were related to less guidance; low self-esteem, guilt and helplessness were related to less social integration.

Finally, relationships between the individual depression subscales and an external locus of control were such that: 1) at one month postpartum, greater guilt and pessimism were associated with an external locus of control; 2) at two months postpartum, more fatigue was associated with an external locus of control; and 3) at five months postpartum, greater symptoms of low self-esteem and pessimism were associated with an external locus of control.

Discussion

Transition Difficulty. Within this sample, which was primarily middle and upper middle class, a significant difference across time was found for only one of the major variables, parental restrictions and responsibilities, as measured by the Transition Difficulty instrument. Two life style changes, which new mothers experience as problematic

during the early months of postpartum, account for the variability in parental restrictions: loss of sleep and not getting out of the house during the day. These difficulties are most prominent during the first month postpartum but decrease significantly between the second and fifth month postpartum. This finding supports Gordon's (1959; 1965) view that postpartum stress and maternal role conflict are linked to the day-to-day life style changes, which accompany the birth of the first child. Therefore, new mothers might find practical assistance and guidance useful in planning and/or compensating for the difficulty these life style limitations pose during the early postpartum weeks.

An additional PRR item, worrying about being a good mother, displayed a moderate decrease over time. Given a larger sample size, this trend in all probability would have been statistically significant, which suggests that another negative aspect of new parenthood reflects an emotional concern regarding one's ability to mother effectively. The recognition of this concern as a problem for first-time mothers is consistant with previous research, which noted associations between feelings of "mothering inadequacy" and anxiety and mood state (Leifer, 1980; Fleming, Flett, Ruble and Shaul, 1988).

The parental gratifications dimension of transition difficulty remained stable during the first five months

postpartum. The finding of no significant variability in parental gratifications confirms previous studies, which have reported fewer rewards in the parenthood role for middle and upper middle class and higher educated subjects as compared to lower class and less educated subjects.

The finding that the marital intimacy and stability dimension of transition difficulty remained stable is in contrast to previous research, which has illustrated dramatic declines in marital quality throughout the first twelve months postpartum (Belsky, Lang, & Rovine, 1985). One explanation for these contradictory findings may be that the previous study examined the marital relationship from a more global perspective, assessing such qualities as marital satisfaction, positive maintenance behaviors related to the marital relationship, feelings of love, and identification of the marriage as a friendship and romance (Belsky, et al., 1985). The present study questioned mothers about their marital relationship in juxtaposition to the new parenthood role, which new mothers may find psychologically threatening. As Hobbs (1968) had suggested previously, a questionnaire in contrast to an interview may mask new mothers' negative feelings about their infants experienced during the early postpartum period. Additionally, given the present understanding of the interactive nature of mother-infant attachment and the significance of the early

bonding process, psychological denial of negative feelings during the early postpartum period may be a function of the primipara's role in the newly developing mother-child relationship.

Social Support. In terms of social support, the current investigation, found little to no change in total social support or individual social support provisions during the first five months postpartum. In previous research with demographically comparable samples, Belsky & Rovine (1984) found that social support was highest during the first three months postpartum and declined by nine months pospartum. In addition, Cutrona (1984) found that while overall social support did not appear to vary from one to twelves months postpartum, in fact, decreases in three types of social support, reassurance of worth, attachment, and social intergration, offset a large increase in nurturance. The nurturance provision is conceptually very different than the other provisions as it reflects giving care to another person rather than receiving relational benefits from others. However, unlike the previous studies, the social support results in the current investigation demonstrate no significant variability across time. The lack of variability may be due to the homogeneity and high personal resources of the sample in this study. As a group the sample was middle to upper middle class, had higher

education, an older mean age, and an elevated mean social support score as compared to Cutrona's sample, which suggests that high resource individuals such as these may not experience significant decreases in social supports that provide benefits to mothers during the first months of postpartum. However, the short-term longitudinal focus of the present study also may have limited the findings. Within the two previous studies, social support decreases may have become more evident as postpartum was defined as a twelve month period. Nonetheless, the current investigation suggests that new mothers who have established a social support system prior to giving birth can benefit from those social relationships in terms of having both their concrete and emotional needs met at least through the first six months postpartum.

Theoretically, locus of control is conceptualized as a personality trait and therefore, is not expected to vary. However, as some studies have noted increased dependency in new mothers during postpartum, particularly in relationship to the husband (Leifer, 1980; Oakley, 1980), it was hypothesized that locus of control might vary in this population. Locus of control, however, did not differ significantly during the first five months postpartum in the present study. In addition, while previous research on high resource individuals, (middle class, higher education, etc.)

had found an association between better psychological functicning and an internal locus of control (Eckenrode, 1983; and Riley and Eckenrode, 1986), the sample in the present investigation, which was also a high resource group, had a predominantly external locus of control. Therefore, the current research results do not support the hypothesis of variability in locus of control in primiparae across the early months of postpartum; ncr do the results substantiate previous findings of an association between better psychological functioning in high resource individuals and an internal locus of control. However, a methodological limitation in the current study was the lack of a prenatal assessment of locus of control, which would have clarified whether this sample of high resource individuals had an external locus of control prior to childbirth or if it showed variability as a function childbirth. In either case, as these mothers appear to be well-functioning, the indication of "externality" suggests that locus of control may be irrelevant to primiparae's ability to function well during early postpartum given a particularly high degree of individual resources.

Few relationships were found between the major variables, as well. The only significant association found between the marital intimacy and stability dimension of transition difficulty and the social support provision,

guidance, indicates that new mothers who have access to authoritative individuals who can provide information, advice, and guidance when needed, experience fewer concerns and worries regarding the quality of their marital relationship. This observation may partially explain earlier research which demonstrated that the quality of the marital relationship drops dramatically for well-functicning, middle class primiparae during the first year postpartum (Belsky & Rovine, 1985). So that, even though the marital relationship changes focus during the postpartum transition to parenthood from the adults' emotional needs to the infant's instrumental needs and from a romance to a partnership, new mothers who continue to function well may utilize available authoritative individuals to help them understand and adjust to those changes. If guidance needs gc unmet, new mothers may be left with unresolved worries and fears related to maintenance of the companionable aspects of the marital relationship.

Supplementary analyses in this investigation demonstrated a comparable level of depression in this sample to previous research on clinical postpartum depression in primiparae (Kruckmann, 1986). However, neither overall depression nor individual symptoms cf depression demonstrated significant change during the first five months

postpartum of the current investigation. One implication of this finding involves previous research which has found that dysphoria is associated with fewer affectionate and social interactions between mother and infant. This in turn effects a woman's negative sense of herself as a mother (Williams, et al., 1987; Fleming, et al., 1980). Therefore, new mothers' depressive symptomology may need to be addressed during early postpartum in order for her to have a full range of interactions with her infant and to feel positively about herself in the mothering role.

In addition, a number of relationships were found between depressive symptomology and dimensions of the transition difficulty and social support. For example, at one month postpartum, less total social support was related to greater overall depression and lower levels of self-esteem which suggests that without adequate social support provisions, new mothers experience more depression and lower feelings of self worth at the end of four weeks postpartum. At two months postpartum, an association between the depressive symptom of irritability and the marital intimacy and stability dimension of transition difficulty indicates that irritability by eight weeks postpartum poses a threat to new mothers in terms of fears and worries regarding their ability to maintain the companionable aspects of the marital relationship.

In addition, less total social support is associated with more sad mood. Therefore, although the total social support sample mean in the present study is very high when compared to earlier research (e.g. Cutrona, 1984), this finding suggests that the degree of relational provisions which social supports provide to new mothers is relative. Therefore, it may not simply be the quantity of social provisions but the quality or function they provide new mothers at eight weeks postpartum that effects postpartum mood.

Finally, at five months postpartum, mothers who felt pessimistic reported fewer gratifications in the parenting role, which suggests that with little hope for positive future outcomes, parenthood is perceived as a role that provides few rewards to the mother. Moreover, mothers with a depressive symptom of social introversion at five months postpartum, reported more worries and concerns in being able to maintain the companionable aspects of the marital relationship. Also, associations between overall depression and individual depressive symptoms of fatigue, guilt, pessimism, and helplessness and total social support indicate that the less the overall social support, the greater the total depression and categories of symptomology found in new mothers at five months postpartum.

Moreover, specific provisions of social support were associated with individual depressive symptomology. Such as, at one month postpartum, the observation of the less available reliable alliance or consistent, practical assistance is for primiparae, the more difficulties they will experience with self-esteem and helplessness. An association between helplessness and social integration suggests that new mothers need to feel part of a meaningful social group with which they can share experiences. Shared experiences probably provide normalizing and problem solving opportunities for new mothers, which may decrease feelings of helplessness in the face of common postpartum stresses. An association between cognitive difficulty and low energy and less reassurance of worth, suggests that the intellectual disorganization and fatigue often experienced in the first month of postpartum may reflect new mothers' personal need to have their abilities valued and acknowledged within the first four weeks of postpartum as they begin to take on the mothering role in relationship to their infant.

At two months postpartum, difficulties with low self-esteem and helplessness were related to less attachment or sense of security and safety within the support system. The number and intensity of a woman's role changes within family, social and work groups might threaten a new

mother's sense of control in her ability to function effectively and sense of herself until she feels safe and secure in her renewed social relationships. Sad mood associated with guidance and social integration at eight weeks postpartum indicates that new mothers who have fewer individuals to turn to for advice and guidance and less of a social group with which to share interests are sadder than mothers who have those support. Finally, at two months postpartum, low self-esteem and sadness were related to less reassurance of worth or less acknowledging and valuing of a new mother's abilities, which suggests that new mothers need positive reinforcement regarding the mothering role in order to feel less sad.

At five months postpartum, fatigue, low self-esteem, guilt, pessimism, and helplessness were related to less consistent, practical help and less of a sense of security and safety. These findings suggest that if the continuing need for practical assistance and the lack of a sense of emotional security and safety is not addressed for new mothers by five months postpartum, primiparae experience a number of depressive symptoms. Also, indadequate information and guidance leads to pessimism and helplessness in new mothers, as they are in all probability unable to feel positive about their ability to problem solve and thereby, gain some control over the difficulties common to

new parenthood. Finally, at five months postpartum, the less a new mother feels part of a social group with whom she shares interests and concerns, the lower her self-esteem and the greater her guilt and sense of helplessness. Again, a meaningful social group can probably provide normalizing and problem-solving opportunities which counterbalance a new mother's feelings of inadequacy and poor self-esteem related to inexperience.

In terms of the personal resource, locus of control, an external locus of control or belief that one's behavior will not have much of an effect upon outcomes is associated with more guilt and feelings of helplessness at one month postpartum; more fatigue at two months postpartum,; and lower self-esteem and more pessimism at five months postpartum. These findings suggest that the relationship between time and an external locus of control delineated depressive symptomology for first-time mothers in this sample.

In conclusion, as only one of the major variables displayed a difference across time and only one significant relationship was found between the major variables, a number of conceptual and methodological issues may account for these findings. First, the sample, consisting of volunteer subjects, was very homogenous in terms of socioeconomic status, age range, and level of education, which represented

a high resource group. The homogeneity may account for the lack of variability within the group. In addition, the sample mean demonstrated an external locus of control, which is not considered a high personal resource due to its previous association with poorer psychological functioning (Sandler & Lakey, 1982; Eckenrode, 1983; Riley & Eckenrode, 1986). However, the exceptionally high degree of social support in this sample as compared to Cutrona's (1984) social support findings in a socioeconomically and educationally comparable sample, indicates that high social support may counteract the negative effects of an external locus of control. Therefore, while previous research had found less depression in association with an internal locus of control, the present investigation found little variability in transition difficulty or depressive symptomology in association to an external locus of control. The high degree of social support provisions which did not fluctuate across time in this sample may account for that result.

Another methodological issue in the current investigation was the loss of more than fifty-percent of the original sample pool due to attrition. Therefore, the self-selected volunteers in this non-randomized sample may represent only one cohort of the population of interest. Although there was no significant difference between the

sample which completed the investigation at Time 1 only (N = 11) and the completed group (N = 30), the loss of a high proportion of potential subjects limits the potential data as well. In addition, as in limitations related to all self-report assessments, the subjects that completed the study may have self-selected to respond to the questionnaire on a "good" day which may have confounded the results. A larger sample size and more follow through in assessing volunteer mothers more randomly via telephone or home visits, may have minimized the effects of self-selection.

Finally, these subjects represent a specific demographic group as they were older (mean age of 29 years); the majority of which had been married only once (mean years of 1.5 years); with forty-two percent of the sample earning over $35,000 and thirty-one percent earning over $50,000, and seventy-four percent oriented to continuing employment outside the home. Therefore, as this is an initial study, the minimally, significant findings in transition difficulties represents preliminary findings for this demographic sample. Future research might investigate a demographically broader and a larger sample of new mothers to develop baseline data.

Another limitation of the current study may be in the Transition Difficulty measure. Steffensmeier's (1977) measure, which consists of items developed from previous

research on postpartum as crisis and interviews with fifty-seven first-time parent couples. While the measure demonstrates adequate content validity and upon inspection appears to have face validity, it may not be effectively picking up certain aspects of the transition to parenthood. This may be due to parents' psychological reaction to the content. The measure may be asking questions for which new mothers have difficulty responding emctionally. For example, Belsky and Rovine (1986) found dramatic decreases in marital quality during postpartum by asking more generic questions about the marital relationship, rather than referencing questions in relationship to the first child's birth. Therefore, in terms of the current investigation, new mothers may struggle with their own and society's mythical expectations of the "good" mother, which makes them less able to acknowledge the negative aspects of the mothering role in early postpartum (Leifer, 1980; Oakley, 1980). This might explain the apparently contradictory findings of earlier research on postpartum as crisis. Questionnaire studies which found little to no postpartum crisis within one to two years of the first birth, were in contrast to assessments performed between two and five years postpartum, which reported significant crisis. However, in a combined questionnaire-interview study, Hobbs (1968) concluded that negative responses to the difficulty of

postpartum are more readily masked by the questionnaire format. The findings from previous research and the current investigation suggest that it is either distance in time or the opportunity to more fully explain oneself in an interview format which allows first-time mothers to openly acknowledge the negative aspects of the postpartum transition to parenthood.

Otherwise, new mothers may need to utilize the defense mechanism of denial for two purpose in this regard. Firstly, because of the intensity and importance of the mother-infant bonding and attachment process, mothers may feel a need to protect that relatioship by keeping the negative aspects of their early mothering experience out of their consciousness. Secondly, new mothers may feel particularly vulnerable during postpartum as they cope with the myriad of instrumental and affective changes in their lives. This vulnerability may be reflected in increased dependency upon spouses and in fears regarding the maintenance of the companionable aspects of the marital relationship. This vulnerability comes at a time when new mothers are in most need of practical and emotional spousal support. Therefore, denial may be an effective means for new mothers' to cope with fears regarding the threat of loss of the marital relationship following the birth of the first child.

This investigation has been an initial longitudinal study of the normal, developmental adjustment in the transition to parenthood. While social support and locus of control have been found to be effective mediators of stress in relationship to postpartum depression (Cutrona, 1984; Riley & Eckenrode, 1986), their role in relationship to the normal difficulty of the postpartum transition into parenthood remains unclear. Therefore, there is a need to develop instrumentation and methodology that will better assess the dramatic changes which many first time mothers report clinically (Leifer, 1980; Oakley, 1980) and which have been confirmed empirically to a limited degree (Belsky & Rovine, 1986).

Future research might examine the normal adjustment in the transition to parenthood through a more comprehensive longitudinal design which would include a prenatal and postnatal assessment of important variables and a duration of at least a full year so as to examine normal, developmental change more comprehensively. Directions for future research might also examine postpartum beyond one year to note the development of parenthood beyond the early months of transition difficulty. The variables and appropriate measures used to assess the positive and negative aspects of the transition might be more general, such as stress factors, marital quality, and changes in

social role, in order to avoid psychological threats to new parents attitudes regarding their infants and their sense of themselves as parents.

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APPENDIX A

Procedures for Securing Subjects

After receiving approval from the IRB, and the Chairperson and Head Nurse of the Department of Obstetrics and Gynecology, the investigator met with the day shift nursing staff during a regularly scheduled meeting. The investigator introduced herself and the proposed research at this time. The investigator also presented a weekly schedule for visiting the obstetrical unit to survey medical charts for potential subjects and to meet prospective subjects. This initial staff meeting was intended to introduce the investigator who was unknown to the majority of the staff so that she could move freely throughout the unit and have access to medical charts as needed. This meeting was also intended to address any concerns or questions the staff might have regarding the nature of the study and its effects upon the patients. The nurses gave their verbal support of the study at that time.

The investigator visited the obstetrical unit every other day until a total of 65 subjects had been obtained. The investigator entered each patient's room with their permission. After a social greeting and introduction of the researcher's name and affiliation with the hospital and university, the investigator explained the purpose of the

hospital visit and outlined requirements for participation in the study. Each patient was assured verbally and in writing that their participation or refusal to participate in the study would not effect their on-going medical care and that they had the right to discontinue their participation should they choose to do so at any point in time. The investigator gave each patient a brochure which summarized this discussion during the hospital visit. The brochure is included in Appendix B. In addition, each patient was asked at the time of the hospital visit to fill out a written permission form included with the brochure. The permission form allowed the investigator to contact the patient at home following their hospital release. It was explained to each patient that the permission form was not an agreement to participate in the study but a statement of interest and willingness to be contacted for further consideration.

The investigator then contacted each patient, who had signed the permission form in the hospital, by telephone two to three weeks following their hospital release to determine their subsequent willingness to participate in the research. All potential subjects (N=65) agreed to participate at the time of this telephone call. Following each patients' telephone agreement to participate in the study, the

investigator sent the first questionnaire between 3 and 4 weeks postpartum. The initial questionnaire included an informed consent form, a demographic data sheet, and a cover letter detailing instructions for filling out the questionnaire. The second and third questionnaires, which only included a cover letter detailing instructions for filling out the questionnaire, were mailed between 7 and 8 weeks, and 19 and 20 weeks postpartum, respectfully. Copies of the cover letters, the informed consent form, and the questionnaire are included in Appendix B. The investigator then telephoned each participant approximately one week after the mailing of each questionnaire to verify its receipt and to encourage its completion.

APPENDIX B

TO ALL NEW MOTHERS:

I have had a long-standing interest, both professional and personal, in families, especially young families with newborns. I am about to begin a research project on mothers of first born infants. I would appreciate your consideration to participate in this study. The following information will explain who I am and what would be asked of you.

Thank you for your time.

Kathleen Occhipinti

ABOUT THE RESEARCHER:

Kathleen Occhipinti, Faculty, St. Joseph Family Practice Residency Program; Doctoral Candidate, Loyola University of Chicago.

DESCRIPTION OF VOLUNTEERS:

New Mothers of first born infants with no previous births who consent to participate in the study. (Your refusal to be in the study will NOT affect your continuing medical care.)

VOLUNTEER ACTIVITIES:

Each mother will be mailed a packet of materials containing some forms to be filled out at 3 different points in time: 1 month postpartum, 2 monthes postpartum, 5 monthes postpartum.

RESEARCH ACTIVITIES (Con't.):

The forms will take about 30 minutes to fill out and have to be returned to the researcher within a week. A stamped, self addressed envelope will be included to return mail the forms.

GOAL OF THE RESEARCH:

The information gathered in this study will further our understanding of first-time mothers and their infants during the post-partum period. Use of a numerical code will keep responses anonymous and confidential.

CONSENT FORM:

Please fill out the attached consent form if you are willing to be contacted for further consideration in this study. You will then be contacted by telephone and the forms will be mailed to you. (Should you desire, you may withdraw from the study at any time, which will NOT affect your medical care)

FOR FURTHER INFORMATION:

If you have any further questions or comments, please feel free to call me at any time at 337-1982 or 275-7622, which is an answering machine and I will return your call as soon as possible.

Again, thank you for your time in reading this and any consideration you can give this study.

CONSENT FOR PARTICIPATION

I am willing to be contacted by telephone for consideration in the Research Study on New Mothers _____
(Signature)

PLEASE PRINT:

NAME: _____

ADDRESS: _____ ZIP: _____

TELEPHONE: _____

MOTHERS DATE OF BIRTH: _____ BABY'S DATE OF BIRTH: _____

RE: Study of New Mothers

Dear

Firstly, let me again extend my thanks to you for participating in this study. Hopefully, it will not take too much of your time as I am aware of the demands of a new infant.

Enclosed you will find a questionnaire and a self-addressed stamped envelope. Please fill the questionnaire out as soon as possible and return mail it to me by .

Please answer all questions as honestly as possible. If some questions do not seem to apply to you or are difficult to decide upon, choose an answer which best seems like you, even it is not an exact "fit". Also, please remember that your responses will be treated anonymously.

If you have any questions or comments, please call me at St.Joseph Health Center, 337-1982 afternoons or 275-7622 evenings or mornings. If I am not available at the time you call, I will return your call as soon as possible.

Again, thank you for your continuing support on this project. Your participation will broaden our understanding of new motherhood.

Sincerely,

Kathleen Ccchipinti, M.Ed.
Behavioral Scientist

INFORMED CONSENT

I, , agree to participate in study of first-time mothers. I understand that I will be mailed questionnaires at three different times and that the questionnaires will teake approximately 30 to 40 minutes to fill out. I understand that my responses will be kept confidential and anonymous at all times. I understand that this study poses no known risk to me. However, I am aware of my right to withdraw from the study at any time. Participation in this study or my withdrawal from it will have no effect on the continuation of my medical care.

Volunteer Signature

APPENDIX C

Demographic Questionnaire

1. What is the date of your infant's birth:

2. What is your age:

3. What is the highest level of education you have completed (in years):

4. What is your current marital status:

1	Married	4	Living with someone
2	Remarried	5	Divorced or separated
3	Single	6	Widowed

5. What is your current employment status: your spouse's status?

	YOU	SPOUSE
1 Fulltime homemaker		
2 Employed fulltime		
3 Employed part-time		
4 Unemployed		
5 Maternity Leave		
6 Length of leave		

6. Do you:

1	own your home	2	rent	3	other

7. Is your household income (before taxes):

1	Less than $20,000
2	$20,000 - $34,999
3	$35,000 - $49,999
4	over $50,000

I-E Scale

Instructions: Select one statement of each pair which you more strongly believe to be the case as far as you're concerned. Black-in your choice on the answer sheet.

1.a. Children get into trouble because their parents punish them too much.
b. The trouble with most children nowadays is that their parents are too easy with them.

2.a. Many of the unhappy things in people's lives are partly due to bad luck.
b. People's misfortunes result from the mistakes they make.

3.a. One of the major reasons why we have wars is because people don't take enough interest in politics.
b. There will always be wars, no matter how hard people try to prevent them.

4.a. In the long run people get the respect they deserve in the world.
b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.

5.a. The idea that teachers are unfair to students is nonsense.
b. Most students don't realize the extent to which their grades are influenced by accidental happenings.

6.a. Without the right breaks one cannot be an effective leader.
b. Capable people who fail to become leaders have not taken advantage of their opportunities.

7.a. No matter how hard you try some people just don't like you.
b. People who can't get others to like them don't understand how to get along with others.

8.a. Heredity plays the major role in determining one's personality.
b. It is one's experiences in life that determine what they're like.

9.a. I have often found that what is going to happen will happen.
b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

10.a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
b. Many times exam questions tend to be so unrelated to coursework that studying is really useless.

11.a. Becoming a success is a matter of hardwork, luck has little or nothing to do with it.
b. Getting a good job depends mainly on being in the right place at the right time.

12.a. The average citizen can have an influence in government decisions.
b. This world is run by the few people in power, and there is not much the little guy can do about it.

13.a. When I make plans, I am almost certain that I can make them work.
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.

14.a. There are certain people who are just no good.
b. There is some good in everybody.

15.a. In my case getting what I want has little or nothing to do with luck.
b. Many times we might just as well decide what to do by flipping a coin.

16.a. Who gets to be the boss often depends on who was lucky to be in the right place first.
b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.

17.a. As far as world affairs are concerned, most of us are victims of forces we can neither understand, nor control.
b. By taking an active part in political and social affairs the people can control world events.

18.a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
b. There is really no such thing as "luck."

19.a. One should always be willing to admit mistakes.
b. It is usually best to cover up one's mistakes.

20.a. It is hard to know whether or not a person really likes you.
b. How many friends you have depends upon how nice a person you are.

21.a. In the long run the bad things that happen to us are balanced by the good ones.
b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.

22.a. With enough effort we can wipe out political corruption.
b. It is difficult for people to have much control over the things politicians do in office.

23.a. Sometimes I can't understand how teachers arrive at the grades they give.
b. There is a direct connection between how hard I study and the grades I get.

24.a. A good leader expects people to decide for themselves what they should do.
b. A good leader makes it clear to everybody what their jobs are.

25.a. Many times I feel I have little influence over the things that happen to me.
b. It is impossible for me to believe that chance or luck plays an important role in my life.

26.a. People are lonely because they don't try to be friendly.
b. There's not much use in trying too hard to please people, if they like you, they like you.

27.a. There is too much emphasis on athletics in high school.
b. Team sports are an excellent way to build character.

28.a. What happens to me is my own doing.
b. Sometimes I feel that I don't have enough control over the direction my life is taking.

29.a. Most of the time I can't understand why politicians behave the way they do.
b. In the long run the people are responsible for bad government on a national as well as on a local level.

Short Form Multiscore Depression Inventory

This is a questionnaire designed to discover some of your typical feelings and attitudes. Your task is to read each item very carefully and decide whether or not that item is true for you. There are no right or wrong answers, since different people have different attitudes and moods. We are interested in how you usually feel, about yourself and about your world. Answer each item on your answer sheet either true (T) if it usually applies to you, or false (F) if it does not usually apply to you. Remember to mark on your answer sheet and not on this test sheet.

1. My thoughts are often jumbled.
2. I often feel droopy and tired.
3. I generally feel inferior.
4. I often have a heavy conscience.
5. The fewer people around me, the better I feel.
6. My future looks rosy.
7. I don't often argue with people.
8. I frequently feel high in spirits.
9. People do not treat me fairly.
10. I usually make decisions easily.
11. I often feel sluggish and slowed down.
12. I frequently feel useless.
13. I hardly ever regret any of my actions.
14. I am a loner.
15. My future seems to get better and better.
16. I flare up when someone crosses me.
17. I am a happy person.
18. No-one ever considers how I might be feeling.
19. My thoughts keep going round in circles.
20. My energy level is usually high.
21. My opinion of myself is fairly high.
22. I have let myself down many times.
23. I usually don't mind being in crowds.
24. Things keep getting better in my life.
25. I am short tempered most of the time.
26. I usually feel pretty down.
27. I usually get adequate consideration.
28. My thought processes are crisp and precise.
29. I am usually full of pep.
30. I often feel that I am worthless.
31. I often feel bad about the things I've done.
32. I usually wish people would just leave me by myself.
33. My future, for the most part, looks pretty bright.
34. I fly off the handle easily.
35. I frequently feel blue.
36. Nobody ever seems concerned enough about me.
37. My mind is usually buzzing with confusion.
38. My vitality is usually high.
39. I never seem to do anything right.
40. I do many things that I later regret.
41. I am a sociable and outgoing person.
42. I often think negatively about the future.
43. I usuallly have a nasty temper.
44. I always have trouble making important decisions.
45. I usually feel lively and energetic.
46. I am sure most people find me boring.
47. I often feel guilty.

Transition Difficulty Measure

There are many worries that come with having a new baby to care for. Please read the following list of some things that have bothered others and for each item please score how much you have experienced it:

Not at all	A Little Bit	A Fair Amount	A Great Deal
1	2	3	4

1. Worry about being a good mother. _____
2. Worry about the added responsibility of a child. _____
3. Worry about drifting apart from your spouse. _____
4. Worry about sexual relations. _____
5. Worry about changes in marital relationship. _____
6. Worry about not having enough time to spend with spouse. _____
7. Worry about not giving spouse enough attention and affection. _____

The following is a list of some things which persons have enjoyed since the birth of their first child. Please score each to the extent that you have experienced them:

Not at all	A Little Bit	A Fair Amount	A Great Deal
1	2	3	4

8. A purpose for living. _____
9. Feeling of fulfillment. _____
10. Feeling closer to spouse. _____
11. Satisfaction in continuing your name and family line. _____

The following is a list of some of the changes women experience with their spouses after a baby is born. Please score each item a) how much change there has been, and b) how you feel about this change:

a) HOW MUCH CHANGE there has been:

A lot more	Somewhat more	No change	Somewhat less	A lot less
1	2	3	4	5

b) HOW YOU FEEL about the change:

Enthusiastic	Satisfied	Doesn't matter	Somewhat dissatisfied	Very dissatisfied
1	2	3	4	5

	HOW MUCH CHANGE (a)	HOW YOU FEEL (b)
12. Getting together with friends.	_____	_____
13. Not being able to get out in the evening with spouse to movies, to shop, etc.	_____	_____
14. Attention you get from your spouse.	_____	_____
15. Doing things spontaneously.	_____	_____
16. Getting on each other's nerves.	_____	_____
17. Understanding you receive from your spouse.	_____	_____
18. Talking with your spouse.	_____	_____
19. Regularity of daily activities.	_____	_____

Many women experience problems after the birth of their first baby. Please score the following to the extent <u>each has bothered you</u>:

A lot	Somewhat	Not at all
1	2	3

20. Loss of sleep.

21. Being interrupted by the baby in the middle of doing something. _____

22. Not being able to get out of the house during the day. _____

Some people feel differently about themselves after the birth of their first baby. Please score the following to the extent <u>you feel the same or differently</u> about yourself:

A lot more	Somewhat more	About the same	Somewhat less	A lot less
1	2	3	4	5

23. Happy. _____

24. Lonely. _____

25. Important. _____

Social Provisions Scale

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4

1. There are people I can depend on to help me if I really need it. _____
2. I feel that I do not have any close personal relationships with other people. _____
3. There is no one I can turn to for guidance in times of stress. _____
4. There are people who depend on me for help. _____
5. There are people who enjoy the same social activities I do. _____
6. Other people do not view me as competent. _____
7. I feel personally responsible for the well-being of another person. _____
8. I feel part of a group of people who share my attitudes and beliefs. _____
9. I do not think other people respect my skills and abilities. _____
10. If something went wrong, no one would come to my assistance. _____
11. I have close relationships that provide me with a sense of emotional security and well-being. _____
12. There is someone I could talk to about important decisions in my life. _____
13. I have relationships where my competence and skill are recognized. _____
14. There is no one who shares my interests and concerns. _____
15. There is no one who really relies on me for their well-being. _____
16. There is a trustworthy person I could turn to for advice if I were having problems. _____

17. I feel a strong emotional bond with at least one other person. _____

18. There is no one I can depend on for aid if I really need it. _____

19. There is no one I feel comfortable talking about problems with. _____

20. There are people who admire my talents and abilities. _____

21. I lack a feeling of intimacy with another person. _____

22. There is no one who likes to do the things I do. _____

23. There are people I can count on in an emergency. _____

24. No one needs me to care for them anymore. _____

APPENDIX D

Procedures for Scoring Transition Difficulty

Subjects are required to rate 25 items within five categories of questions on a fluctuating scale. The first category includes items 1 through 7 and reflects worries related to having a new baby, such as "worry about the added responsibilities of a child." The subject is required to rate the degree of worry on a scale ranging from 1 - 4. A one indicates "not at all" and four indicates "a great deal". Items 8 through 11 reflect rewards of motherhood such as experencing a "feeling of fulfillment." The scale for these items ranges from 1 - 4 as in the above category. Items 12 through 19 reflect changes in lifestyle, such as "doing things spontaneously." Each of these items require two separate responses. The first response requires the subject to rate the amount of change she has experienced in her lifestyle on a scale ranging from 1 - 5. A one indicates "a lot more" and five indicates "a lot less." The second response requires the subject to rate how she feels about the changes in her lifestyle on a scale ranging from 1 - 5. A one indicates "enthusiastic" and a five indicates "very dissatisfied." Items 20 through 22 reflect the amount of bother experienced with common problems such as "loss of sleep". The subject is required to rate the degree of bother on a scale

ranging from 1 - 3. A one indicates "a lot" and three "not at all." The final items, 23 through 25 reflect one's sense of self, such as feeling "lonely." The subect is required to rate descriptors of her sense of self on a scale ranging from 1 - 5. One indicates a "lot more" to 5 a "lot less."

Scoring the instrument yields a value for each of three subscales representing the multidimensions of the transition to parenthood: 1) parental responsibilities and restrictions (PRR) which reflect the concrete effects of the baby's birth upon parents' lifestyle; 2) parental gratifications (PG) which reflect the positive rewards or gratifications of parenthood and resulting changes in self-concept; and 3) marital intimacy and stability (MIS) which reflect parents' concerns regarding the maintenance of the "companionable relationship with the spouse" following the birth of the first child (Steffensmeier, 1982).

A score for each dimension of transition difficulty is obtained by reversing the scores of a number of items and then summing those items which comprise each of the three dimensions. Therefore, for items 8, 9, 10, and 11, with a range from 1 to 4, scores of one and four are reversed; and scores of two and three are reversed. For items 32 with a range from 1 to 5, a score of one or five are reversed;

scores of two or four are reversed; and a score of three remains the same. For items 28, 29, 30, with a range from 1 to 3, scores of one or three are reversed, and two remains the same. Each dimension of transition difficulty is summated as follows. The parental restrictions and responsibilities (PRR) score is the sum of eight items: 1, 2, 13, 15, 27, 28 reversed, 29 reversed, and 30 reversed. The parental gratifications (PG) score is the sum of ten items: 8 reversed, 9 reversed, 10 reversed, 11 reversed, 17, 19, 21, 31, 32 reversed, and 33. The marital intimacy and stability (MIS) score is the sum of seven items: 3, 4, 5, 6, 7, 23 and 25.

Items 12, 14, 16, 18, 20, 22, 24, and 26 are not included in the summated score. While these items are used to identify the degree of change, it is the <u>quality</u> of change that is of interest in this measure. Therefore, it is the paired item, which assesses the quality of change that is included in the summated score in the present study.

APPENDIX E

Summary of Demographic Data

N=30	Frequency	Percent
Age		
25	1	3.3
26	3	10
27	3	10
28	6	20
29	5	16.7
30	1	3.3
31	1	3.3
32	4	13.3
33	1	3.3
34	4	13.3
36	1	3.3
Race		
Black	4	13.3
White	21	70
Hispanic	3	10
Asian	2	6.7
Educational Level		
1. Grammar school	0	0
2. Completed high school	5	16.7
3. Some college	10	33.3
4. Completed college	9	30
5. Graduate school	6	20
Income Level (N=29)		
1. $0-20,000	1	3.3
2. $20,000-35,000	7	24.1
3. $35,000-50,000	12	41.3
4. $50,000+	9	31
Employment Status		
Homemaker	8	26.6
Part-time	3	10
Unemployed	2	6.6
Full-time with maternity leave specified	15	50
Full-time with maternity leave unspecified	2	6.6

Means and Standard Deviations of Age and Years Married

N = 30	Mean	Standard Deviation
Age	29.7	2.95
Years married	2.6	1.81

APPENDIX F

Results of T-Tests for Differences Between Completed Group and Incomplete Group in Major Dependent and Independent Variables at Time 1

Variable	t-ratio	p
Parental Gratifications	-.49	.62
Marital Intimacy and Stability	1.54	.13
Parental Responsibilities and Restrictions	.79	.43
Total Social Support	.78	.43
Locus of Control	-.49	.62
Total Depression	-.59	.55

Completed Group N=30

Incomplete Group N=11

Results of T-Tests for Changes Between Completed Group and Incomplete Group in Social Provisions Subscales at Time 1

Variable	t-ratio	p
Reliable Alliance	.19	.85
Guidance	.34	.73
Nurturance	1.75	.88
Social Integration	1.01	.31
Reassurance of Worth	.68	.50
Attachment	.79	.43

Completed Group N=30

Incomplete Group N=11

Results of T-Tests for Changes Between Completed Group and Incomplete Group in Depression Subscales at Time 1

Variable	t-ratio	p
Cognitive Difficulty	.51	.61
Energy Level	-.27	.78
Self Esteem	.75	.45
Guilt	1.42	.66
Social Introversion	-1.35	.18
Pessimism	-1.15	.25
Irritability	-.76	.45
Sad Mood	-.97	.33
Helplessness	-1.55	.13

Completed Group N=30

Incomplete Group N=11

APPENDIX G

Means and Standard Deviations of Parental Gratifications (PG) Across Time

N=30	Mean	Standard Deviation
Time 1	30.73	4.42
Time 2	31.50	4.54
Time 3	31.73	4.65

One Way MANOVA Test of Parental Gratifications (PG) Across Time

Source	DF	SS	MS	F	P
Between	29	1300.98	48.86	1.01	.36
Within	60	484.66	8.07		
Total	89	1785.65	20.06		

Significance at .05 level

Means and Standard Deviations of Marital Intimacy and Stability (MIS) Across Time

N=30	Mean	Standard Deviation
Time 1	16.03	4.57
Time 2	15.93	4.47
Time 3	16.53	4.53

One Way MANOVA Test of Marital Intimacy and Stability (MIS) Across Time

Source	DF	SS	MS	F	P
Between	29	1211.83	41.78	.31	.73
Within	60	578.66	9.64		
Total	89	1790.50	20.11		

Significance at .05 level

Means and Standard Deviations of Total Social Support Across Time

N=30	Mean	Standard Deviation
Time 1	84.36	7.93
Time 2	83.96	10.69
Time 3	82.86	11.19

One Way MANOVA Test of Total Social Support Across Time

Source	DF	SS	MS	F	P
Between	29	6980.93	240.72	.58	.56
Within	60	1828.66	30.47		
Total	89	8809.60	98.98		

Means and Standard Deviations of Social Provisions Subscale Score: Reliable Alliance

N=30	Mean	Standard Deviation
Time 1	14.66	1.72
Time 2	14.36	2.12
Time 3	14.20	2.42

One Way MANOVA Test of Social Provisions Subscale Across Time: Reliable Alliance

Source	DF	SS	MS	F	P
Between	29	305.78	10.54	1.17	.31
Within	60	86.00	1.43		
Total	89	391.78	4.40		

Means and Standard Deviations of Social Provisions Subscale Score: Attachment

N=30	Mean	Standard Deviation
Time 1	14.16	1.70
Time 2	13.96	1.92
Time 3	13.83	2.36

One Way MANOVA Test of Social Provisions Subscale Across Time: Attachment

Source	DF	SS	MS	F	P
Between	29	262.32	9.04	.53	.58
Within	60	92.66	1.54		
Total	89	354.98	3.98		

Means and Standard Deviations of Social Provisions Subscale Score: Guidance

N=30	Mean	Standard Deviation
Time 1	14.33	1.93
Time 2	14.16	1.98
Time 3	13.96	2.14

One Way MANOVA Test of Social Provisions Subscale Across Time: Guidance

Source	DF	SS	MS	F	P
Between	29	238.48	8.22	.49	.60
Within	60	119.33	1.98		
Total	89	357.82	4.02		

Means and Standard Deviations of Social Provisions Subscale Score: Nurturance

N=30	Mean	Standard Deviation
Time 1	13.60	1.63
Time 2	13.96	1.84
Time 3	13.70	1.93

One Way MANOVA Test of Social Provisions Subscale Across Time: Nurturance

Source	DF	SS	MS	F	P
Between	29	202.62	6.98	.76	.47
Within	60	84.00	1.40		
Total	89	286.62	3.22		

Means and Standard Deviations of Social Provisions Subscale Score: Social Integration

N=30	Mean	Standard Deviation
Time 1	13.96	1.60
Time 2	13.93	2.06
Time 3	13.90	2.09

One Way MANOVA Test of Social Provisions Subscale Across Time: Social Integration

Source	DF	SS	MS	F	P
Between	29	234.93	8.10	.02	.97
Within	60	90.66	1.51		
Total	89	325.60	3.65		

Means and Standard Deviations of Social Provisions Subscale Score: Reassurance of Worth

N=30	Mean	Standard Deviation
Time 1	13.63	1.71
Time 2	13.56	2.09
Time 3	13.26	2.09

One Way MANOVA Test of Social Provisions Subscale Across Time: Reassurance of Worth

Source	DF	SS	MS	F	P
Between	29	269.82	9.30	.94	.39
Within	60	72.66	1.21		
Total	89	342.48	3.84		

Means and Standard Deviations of Depression Subscale Score: Cognitive Difficulty

N=30	Mean	Standard Deviation
Time 1	1.56	1.56
Time 2	1.70	1.55
Time 3	1.50	1.69

One Way ANOVA Test of Depression Subscale Across Time: Cognitive Difficulty

Source	DF	SS	MS	F	P
Between	29	179.78	6.19	.39	.67
Within	60	46.00	.76		
Total	89	225.78	2.53		

Means and Standard Deviations of Depression Subscale Score: Energy Level

N=30	Mean	Standard Deviation
Time 1	1.36	1.80
Time 2	1.73	2.05
Time 3	1.60	1.90

One Way ANOVA Test of Depression Subscale Across Time: Energy Level

Source	DF	SS	MS	F	P
Between	29	218.10	7.52	.57	.56
Within	60	106.00	1.76		
Total	89	324.10	3.64		

Means and Standard Deviations of Depression Subscale Score: Self Esteem

N=30	Mean	Standard Deviation
Time 1	.43	1.04
Time 2	.50	1.33
Time 3	.56	1.33

One Way ANOVA Test of Depression Subscale Across Time: Self Esteem

Source	DF	SS	MS	F	P
Between	29	115.16	3.97	.40	.66
Within	60	19.33	.32		
Total	89	134.50	1.51		

Means and Standard Deviations of Depression Subscale Score: Guilt

N=30	Mean	Standard Deviation
Time 1	1.90	1.64
Time 2	1.43	1.43
Time 3	1.40	1.61

One Way ANOVA Test of Depression Subscale Across Time: Guilt

Source	DF	SS	MS	F	P
Between	29	151.28	5.21	2.19	.12
Within	60	66.66	1.11		
Total	89	217.95	2.44		

Means and Standard Deviations of Depression Subscale Score: Social Introversion

N=30	Mean	Standard Deviation
Time 1	.73	.94
Time 2	.80	.99
Time 3	.73	.98

One Way ANOVA Test of Depression Subscale Across Time: Social Introversion

Source	DF	SS	MS	F	P
Between	29	65.95	2.27	.15	.85
Within	60	16.66	.27		
Total	89	82.62	.92		

Means and Standard Deviations of Depression Subscale Score: Pessimisim

N=30	Mean	Standard Deviation
Time 1	.26	.78
Time 2	.16	.53
Time 3	.30	.98

One Way ANOVA Test of Depression Subscale Across Time: Pessimisim

Source	DF	SS	MS	F	P
Between	29	33.28	1.14	.39	.67
Within	60	21.33	.35		
Total	89	54.62	.61		

Means and Standard Deviations of Depression Subscale Score: Irritability

N=30	Mean	Standard Deviation
Time 1	.90	1.21
Time 2	.83	.94
Time 3	.66	.66

One Way ANOVA Test of Depression Subscale Across Time: Irritability

Source	DF	SS	MS	F	P
Between	29	47.06	1.62	.72	.48
Within	60	35.33	.58		
Total	89	82.40			

Means and Standard Deviations of Depression Subscale Score: Sad Mood

N=30	Mean	Standard Deviation
Time 1	.40	.81
Time 2	.46	1.04
Time 3	.33	.80

One Way ANOVA Test of Depression Subscale Across Time: Sad Mood

Source	DF	SS	MS	F	P
Between	29	49.60	1.71	.39	.67
Within	60	20.00	.33		
Total	89	69.60	.78		

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Means and Standard Deviations of Depression Subscale Score: Helplessness

N=30	Mean	Standard Deviation
Time 1	.33	.92
Time 2	.46	.97
Time 3	.30	.79

One Way ANOVA Test of Depression Subscale Across Time: Helplessness

Source	DF	SS	MS	F	P
Between	29	56.23	1.93	.95	.39
Within	60	14.66	.24		
Total	89	70.90	.79		

VITA

Kathleen White Occhipinti is the daughter of James White and Ann (Quaritsch) White. She was born on June 18, 1946 in Chicago, Illinois.

She graduated from St. Benedict High School in Chicago, Illinois in 1964. She attended the University of Illinois - Chicago, from 1964 - 1965 and from 1969 - 1972. Ms. Occhipinti graduated in 1972 with a B.A. in English Literature.

Ms. Occhipinti began her masters degree in Community Counseling in 1976 and received an M.Ed. from Loyola University of Chicago in December, 1978. She began her doctoral studies in Counseling Psychology at Loyola University of Chicago in December, 1979.

In the course of her doctoral studies, Ms. Occhipinti was granted four assistantships. She completed a two-year, part-time pre-doctoral internship at the Doyle Child and Family Guidance Center.

Ms. Occhipinti has taught high school. She has done consultation for the State Board of Education and private mental health agencies. Ms. Occhipinti has worked as a behavioral scientist for the past four years and as a family therapist for seven years.

The dissertation submitted by Kathleen Occhipinti
has been read and approved by the following committee:

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The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of doctor of philosophy.

2-28-91
Date

Director's Signature